

Montana

MATERNAL AND CHILD HEALTH NEEDS ASSESSMENT

July 2005

*Family and Community Health Bureau
Public Health and Safety Division
Montana Department of Public Health and Human Services*

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES



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July 14, 2005

Ms. Cassie Lauver
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Maternal and Child Health Bureau
Division of State and Community Health
Room 18-31, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Lauver:

It is with pleasure that we submit Montana's 5 Year Maternal Child Health (MCH) Needs Assessment for the 2000-2005 time period. This Needs Assessment has been developed over several years, by staff of the department, student interns from Rollins School of Public Health and the MCHB GSIP program and, most notably, by Dianna Frick MPH, a CDC Public Health Prevention Specialist on assignment in Montana. The Family and Community Health Bureau Advisory Council also assisted in the development by providing input and reviewing drafts of content. Thanks to all of the staff, Advisory Council members, students and Dianna who have done so much work to create this document.

Needs assessment is a dynamic and never-ending task. We anticipate continuing to gather additional information and even modify the information contained in this document as we constantly assess the needs of the MCH population in Montana and the environment in which they live. This needs assessment will inform a strategic planning process for the Family and Community Health Bureau and its partners in Montana in FFY 2006.

This needs assessment provided some of the documentation with which to justify the designation of Montana's 2006 MCH priorities, which were included in the 2006 MCH Block Grant. This needs assessment documents successes in some areas, and continuing need in many others.

We look forward to continued collaboration with statewide partners and ongoing evaluation of infant, child and family health in Montana in order to effectively plan for and address MCH needs in our state.

Sincerely,

Jo Ann Dotson

Jo Ann Walsh Dotson
MCH Director and Chief, Family and Community Health Bureau

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ACKNOWLEDGEMENTS

The Montana Maternal and Child Health (MCH) Needs Assessment was a collaborative effort between many people within the Montana Department of Public Health and Human Services (DPHHS) and throughout the state. The DPHHS Family and Community Health Bureau (FCHB) would like to thank the people who provided information and updates and reviewed the course of action and document throughout the process.

Particular thanks go out to WIC and Head Start staff for their assistance in distributing surveys to clients and returning completed surveys. Their participation and support ensured that the perspective of Montana's maternal and child health population is represented in this needs assessment. Our gratitude is likewise immeasurable for the WIC and Head Start clients and parents who took the time to fill out the surveys and tell us about their health experiences in Montana.

We would also like to acknowledge our appreciation to:

- The FCHB Advisory Council members – for their insight into maternal and child health issues in Montana and continued commitment to promoting the health of Montana children and families.
- Laurie Helzer, MPH and Amee Alderman, MPH – for compiling the initial draft of the 2000-2005 MCH needs assessment and conducting key informant interviews during the summer of 2004.
- Kindra Elgen – for entering the bulk of the needs assessment stakeholder surveys.

Additional information on the needs assessment and maternal and child health in Montana is available from:

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The compilation of the 2000-2005 Montana Maternal and Child Health Needs Assessment was coordinated by Dianna Frick, MPH.

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I. NEEDS ASSESSMENT PROCESS

Montana's maternal and child health needs assessment process is continuous. Data are collected and analyzed throughout the five-year period. The compilation of the needs assessment document is an opportunity to reflect on the complete picture of MCH needs and activities in Montana. Following the submission of the 2005 MCH needs assessment, and using the assessment as a guide, Montana's Family and Community Health Bureau (FCHB) will begin a strategic planning process to further prioritize MCH needs and identify how the FCHB can address them. The strategic planning activities will continue the assessment process and ensure the use of previously collected assessment data. In addition, questions were included on the stakeholder survey sent to providers regarding how the process could be useful to them. The needs assessment results will be distributed to stakeholders around the state and available on the state website, which will help to generate interest in the process and encourage use of the needs assessment results. Finally, counties receiving MCH block grant funds are required to conduct their own needs assessments every five years, and those results are incorporated into the state's data collection process.

Beginning in 2002, meetings were held at the state level to determine how the state would develop the needs assessment. The Family and Community Health Bureau, which is within the Montana Department of Health and Human Services, submitted applications for two student interns in 2003. The students were responsible for conducting key informant interviews with stakeholders throughout the state and updating data from the 2000 needs assessment during June-August of 2004. FCHB also submitted an application for a Centers for Disease Control and Prevention Public Health Prevention Specialist to be assigned to Montana to assess the needs of the MCH populations. The prevention specialist arrived in Montana at the end of August, 2004.

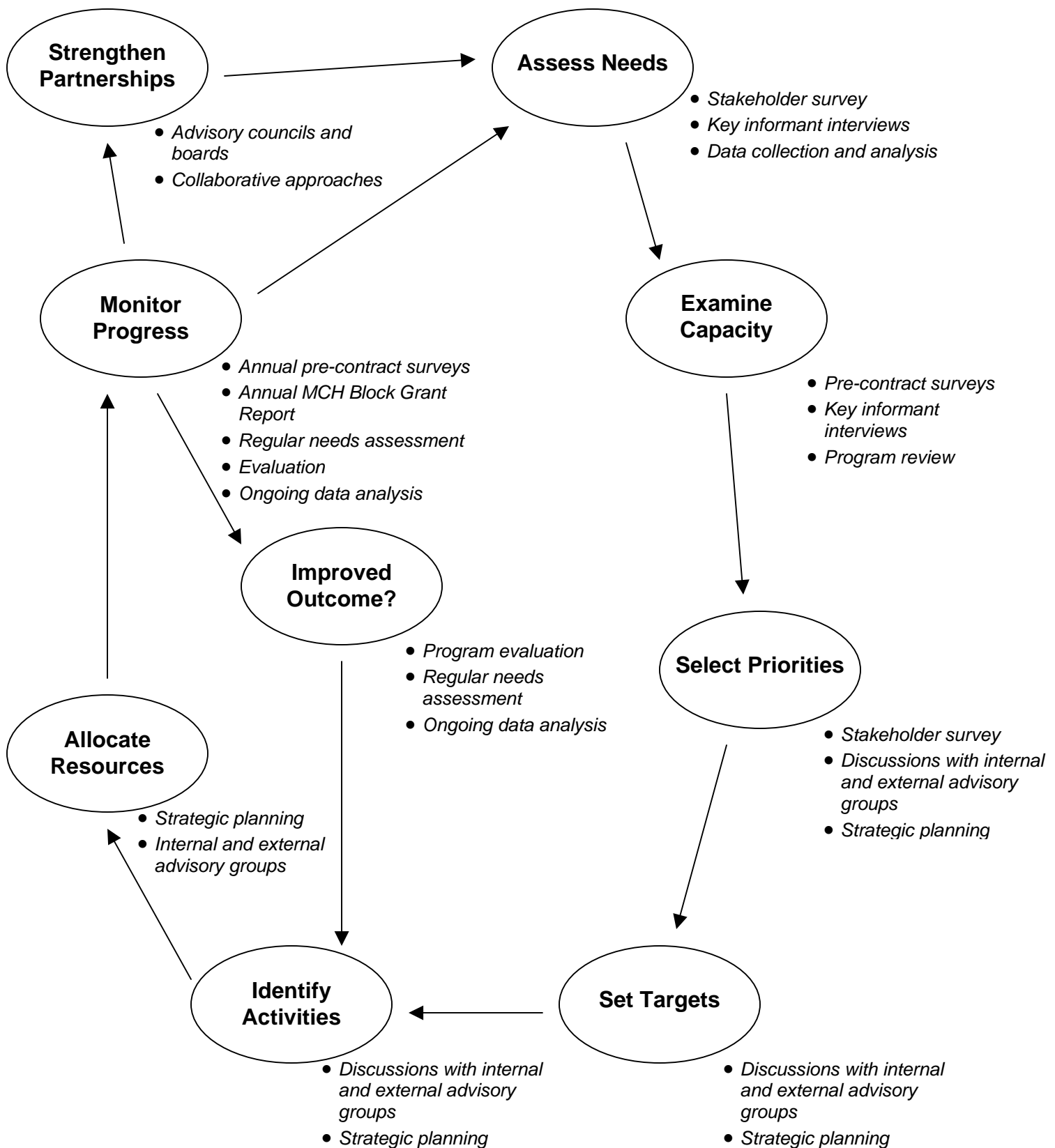
Two groups at the state-level were primarily responsible for shaping and directing the needs assessment process: the Family and Community Health Bureau Advisory Council (FCHB AC) and the Family and Community Health Bureau Managers. The FCHB AC includes representatives from partner organizations throughout the state, including the March of Dimes, local health officers, WIC, family planning, education, urban and rural local health departments, Indian Health Services, nurses associations, and providers. The Council was involved in determining the approach and the final format of the needs assessment survey, as well as reviewing the draft and final documents. The FCHB AC will also be an integral part of the strategic planning process and the ongoing prioritization of maternal and child health needs and activities.

The Family and Community Health Bureau Managers Team is comprised of the chief of the Family and Community Health Bureau and the managers of the four sections of the Family and Community Health Bureau: Maternal and Child Health and Data Monitoring; Child, Adolescent and Community Health; Women's and Men's Health; and, Women Infants and Children (WIC)/Nutrition. The managers decided the approach and focus of the community participation component of the needs assessment, participated in the

development of the surveys, and reviewed and advised on the content of the final needs assessment document.

The graphic on the next page provides an overview of the assessment, planning and monitoring process in Montana and the elements of the MCH and public health systems that are components of each stage.

Overview of the Montana MCH Needs Assessment, Planning and Monitoring Process



Community Participation

Discussions of the best way to collect public input resulted in a decision to use surveys. Past focus groups had had limited participation and key informant interviews were already employed as an information collection tool for the needs assessment. Because of the large size and rural nature of much of the state, it was determined that surveys would be the most time- and cost-effective way to gather input from a large number of people and broad variety of stakeholders.

Respondents were asked to select the top five health needs for maternal and child health populations (infants and young children, children, adolescents, women and, in some cases, children and youth with special health care needs (CYSHCN)) from a defined list. Parent or client respondents were also asked whether they had used a selection of key MCH services. If they did receive services, they were asked to estimate the distance to such services. If they did not receive services, they were asked to list their reasons for not doing so.

Data

Following the discussion of health needs identified by stakeholders is a summary of health status and factors influencing it, according to the MCH population groups: mothers and infants, children and adolescents, and children and youth with special health care needs (CYSHCN). Where possible and appropriate, data for Montana are compared to national or regional statistics or Healthy People 2010 objectives. In some cases, data may not be comparable due to differing methods of data collection or analysis, or lack of available data. Data on one topic from different populations or sources may be used to illustrate possible differences among population groups or to indicate the range of results on the topic of interest.

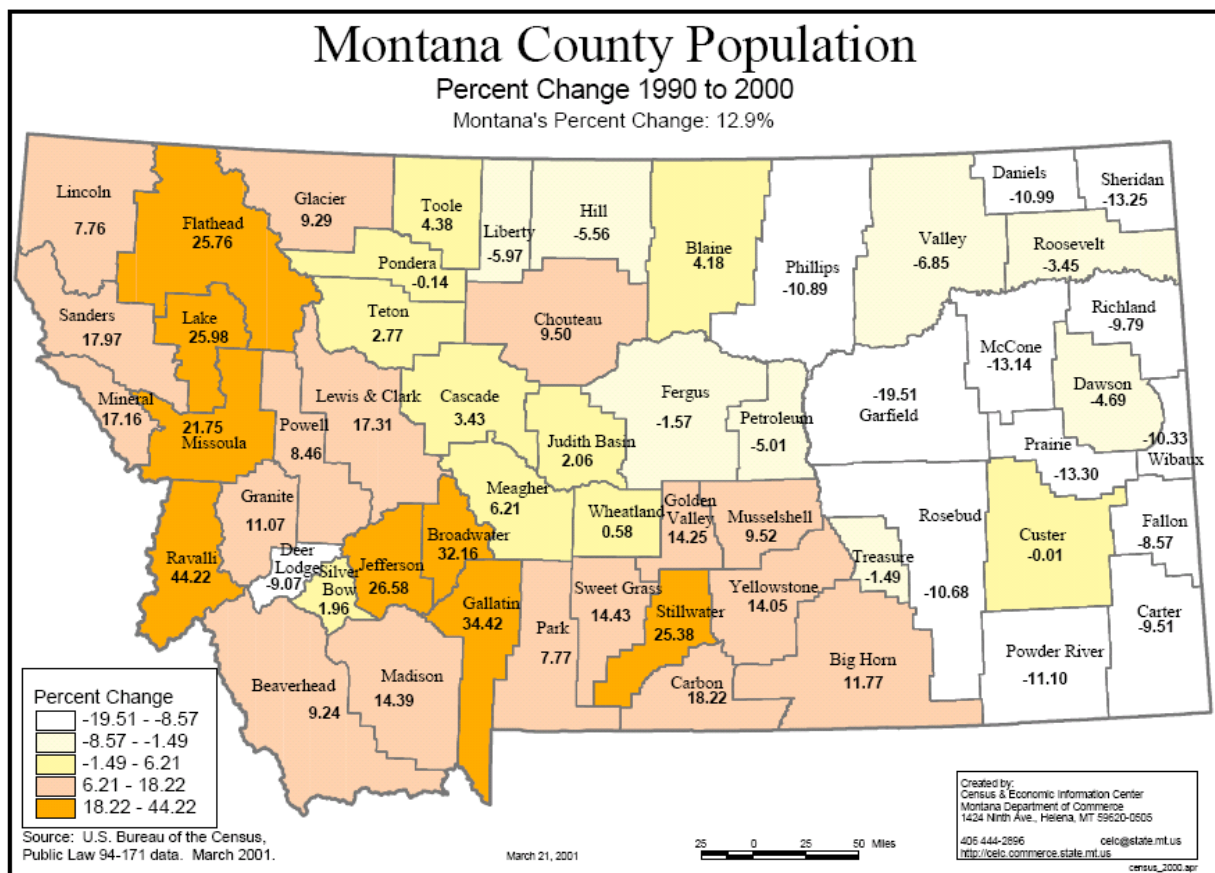
The small size of Montana's population may result in a low number of cases for some outcomes, particularly for uncommon health events. Also, an increase or decrease of one or two cases from one year to the next can result in the appearance of drastic increases or decreases in the rates of some outcomes. Therefore, annual frequencies, rates or calculations may vary widely and be less descriptive than multi-year trends or generalized comparisons, particularly when comparing different data sources on the same topic. When using confidence intervals with statistical calculations, the intervals for Montana data are often wider than for other areas of the country and sample sizes may be small. Where available and appropriate, confidence intervals have been included with data presented in the needs assessment. Major increases in the frequency of a particular event from one year to the next do not necessarily demonstrate a significant increase, and while small numbers of events or outcomes present particular opportunities and challenges in analysis, they are not necessarily an indication of a lack of need.

II. MONTANA DEMOGRAPHICS

Population

Montana is the fourth largest state in the United States, but ranks 44th in terms of population. With 902,195 residents and 145,552 square miles of land, Montana's population density as of 2000 is 6.2 people per square mile. According to 2000 Census data, Montana was one of only 7 states with a population under 1 million and one of only five states with a population density under 10 people per square mile.¹

Between 1990 and 2000, Montana's population increased 12.9%. The 2004 population estimate for Montana is 926,865, representing a 2.7% increase since 2000. While the overall state population continues to increase, within the state the population is shifting west and to more urban areas.



Montana has three metropolitan areas (as defined by the census bureau) and five cities with populations over 10,000. All but one of the seven largest cities are in the western portion of the state. While the cities themselves are generally experiencing quite a bit of population growth, areas immediately surrounding many of the cities are growing even faster. Communities and developments near the population centers offer families more affordable housing and cost of living than some of the largest cities, with the advantage

¹ Demographic Trends in the 20th Century; Census 2000 Special Reports. November 2002. Accessed at: <http://www.census.gov/prod/2002pubs/censr-4.pdf> as of 6-24-05.

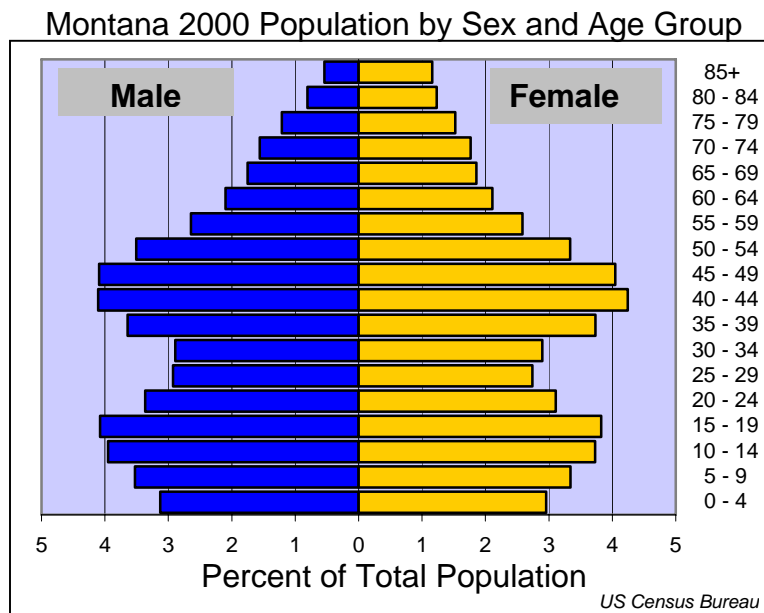
of proximity to the amenities the populous areas have to offer. Lake, Ravalli, Jefferson, Broadwater and Stillwater are all counties that are in close proximity to some of the larger cities and saw population increases of 18.22 to 44.22% between 1990 and 2000.

Seven most populous cities:

City	1990 Population	2000 Population	% Change
Billings	81,151	89,847	10.7%
Great Falls	55,097	56,690	2.9%
Missoula	42,918	57,053	32.9%
Butte/Silver Bow	33,336	33,892	1.7%
Bozeman	22,660	27,509	21.4%
Helena	24,569	25,780	4.9%
Kalispell	11,917	14,223	19.4%

Gender and Age

Montana's population is split evenly between males and females. In 2000, the median age for men was 36.6 and for women was 38.5. Women of reproductive age (15-44 years) comprise 20.5% of the state population, and children and youth under 20 represent 28.5% of the population. Population estimates by age group and gender for 2000 through July 1, 2004 are shown in Appendix A.



Race/Ethnicity

Native Americans are the largest minority group in Montana, accounting for 6.2% of the population, according to the 2000 census. Approximately 56,068 Native Americans reside in the state, the majority on one of seven reservations. Although there are many tribes represented among the Native Americans residing in Montana, the reservations are primarily home to Blackfeet, Crow, Salish, Kootenai, Assiniboine, Gros Ventre, Sioux, Northern Cheyenne, and Chippewa-Cree.

The distribution of race and ethnicity within Montana's population is shown below. Minority groups that may not be captured by census data, but that may have unique health issues include migrant and seasonal farm workers and religious groups such as the Hutterites.

Race/Ethnicity	Total Population	% of Total
White	817,229	90.6
Native American (American Indian)	56,068	6.2
Asian	4,691	0.5
Black/African American	2,692	0.3
Native Hawaiian or Other Pacific Islander	470	0.1
Other race	5,315	0.6
Two or more races	15,730	1.7
Hispanic or Latino (any race)	18,081	2.0

US Census Bureau

Economics

Between 1990 and 2000, the average annual wage in Montana increased from \$23,260 to \$24,264. Montana ranks fairly low compared to other states in average annual wage and median household income. In 2002, Montana ranked 50th out of 50 states for annual average wage (\$26,001), and 46th out of 50 for median household income (\$34,105), according to the Montana Department of Labor and Industry. In 2001, at least 9.3% of employed individuals in Montana held more than one job.² In December of 2004, the top five employment industries in the state were: government; trade, transportation and utilities; education and health services; leisure and hospitality; and, professional and business services.³ Since 2001, Montana's unemployment rate has been lower than the US rate. According to the US Department of Labor, Montana's unemployment rate in 2004 was 4.4%, compared to a US rate of 5.5%.

According to 2002 Census estimates, 25.5% of children under five and 16.7% of children ages five to 17 in Montana live in poverty. Overall, 14% of Montana's population lives in poverty. The 2004 Kids Count Data Book reports that 9% of Montana children live in extreme poverty – income below 50% of the federal poverty level – compared to 7% of children nationally.⁴

2003 Indian Health Services data showed a median household income of \$14,249 on reservations in Montana. Approximately 44.6% of the population residing on reservations live below the poverty line. Twenty-one percent of females and 29.8% of males are unemployed.

Education

In 2002, 89.7% of Montana's population had completed a high school degree compared to 80.4% nationally. As of 2003, 67.6% of Native Americans in Montana had completed

² Montana Economy at a Glance; May 2005. Research and Analysis Bureau, Workforce Services Division, Montana Department of Labor and Industry.

³ Montana Economy at a Glance; December 2004. Research and Analysis Bureau, Workforce Services Division, Montana Department of Labor and Industry.

⁴ 2004 Kids Count Data Book. Annie E. Casey Foundation. Baltimore, MD. 2004.

a high school degree. In 2002, 23.6% of Montana's population had completed a college degree compared to 24.4% nationally. Montana's high school dropout rate in 2001 was 4.2%, the same as the national rate. Among high school dropouts, 57% are males and 43% are females. According to the 2004 Kids Count Data Book, Montana ranks 13th nationally out of 50 in its high school drop out rate.

During the 2003-2004 school year, there were 859 public elementary and secondary schools in Montana. The 2004-03 school year student/teacher ratio was 14.4 students to 1 full-time equivalent (FTE) teacher. In 2002, there were 11 university system campuses, 3 private colleges, 3 public community colleges and 7 tribally controlled community colleges in Montana.

Enrollment in Montana's schools has been decreasing since 1995-96. The Montana Office of Public Instruction (OPI) ascribes the decrease to the state's overall decrease in live births during that time period. However, OPI notes that Native American enrollment has increased by 5% since 1995. Montana's per-pupil expenditures for 2001-2002 were \$7,080, compared to a national average of \$7,524.⁵

The 2004 Kids Count Data Book reports that the test results for Montana's children tend to be better than the national averages. Eighteen percent of 8th graders in Montana scored below basic reading level in 2003, while 28% of 8th graders nationally scored below basic reading level. In the same year, 19% of 4th graders scored below basic math level, compared to 24% nationally.

Insurance

In 2002, 15.2% of Montana residents lacked health insurance compared to 14.7% nationally. There were 17.0% of children without health insurance in Montana compared to 12.1% nationally. In 2002, there were 8.8% of children living in poverty without health insurance compared to 7.5% nationally. Currently about 83,336 people are on Medicaid. According to the 2002 Montana Behavioral Risk Surveillance System (BRFSS) 15.6% of females are uninsured compared to 20.1% of males. In 2002, there were 31.7% of 18-24 year olds uninsured, 19.6% of 25-34 year olds uninsured, 23.2% of 35-44 year olds uninsured, 17.0% of 45-54 year olds uninsured, 15.6% of 55-64 year olds uninsured, and 2.6% of 65 year olds and older uninsured. The uninsured rate for Native Americans in Montana was 54% in 2003

Providers

Of 56 counties, 44 are wholly or partially designated as Health Professional Shortage Areas (HPSA) for primary care (Appendix B). In addition, 15 communities where Federally Qualified Health Centers are located are considered micro-primary care HPSAs⁶. Forty-eight counties are wholly or partially designated as a HPSA for mental health and 37 counties are designated as Dental Health Professional Shortage Areas. 2004 Montana County Health Profiles recorded 881 primary care providers (MDs and

⁵ Facts About Montana Education. Office of Public Instruction. <http://www.opi.state.mt.us/>. Accessed 6/29/05.

⁶ Montana DPHHS Primary Care Office.

DOs) in Montana, 34 nurse midwives, 314 nurse practitioners and 264 physician's assistants. In 2004, eight counties had no primary care providers practicing in them.

The 2004 survey of counties receiving MCH funds indicate that residents of 19 counties have to travel to a different county to receive mental health services, residents of 39 counties have to travel to a different county to receive specialty care, and residents of 25 counties have to travel out of their county to receive delivery services.

Facilities

In 2004, Montana had 21 local hospitals, 40 critical access hospitals with 2,902 total beds, 40 rural health clinics, 20 community health centers and 14 IHS or tribal facilities.

III. STAKEHOLDER SURVEY

A total of 2028 surveys were distributed. The survey was pilot tested in February and early March of 2005 and distribution of the final survey began in March. Over 1100 were returned as of June 30, 2005. 1064 of the returned surveys were from currently practicing public health professionals and parents. The remainder were from providers and public health professionals who are not currently practicing, and thus are not included in the analysis. Surveys were distributed to 10 different groups: WIC parents, WIC staff, Head Start parents, Head Start staff, family practice physicians, OB/GYNs, pediatricians, health staff in youth correctional facilities, school nurses, and county maternal and child health contacts. The survey was limited to two pages (1 page front and back). Copies of the surveys are available in Appendices C and D. No identifying information was listed or requested on any of the surveys except those for the county maternal and child health contacts (required as part of MCH BG funding for this group).

The majority of respondents were asked to identify the top five health needs for each of four MCH populations: Infants and Young Children (defined as children 5 years old and younger), Children (children 6 to 11 years), Adolescents (ages 12 to 21 years), and Women (defined as women who are pregnant or who have recently had a baby). County public health nurses were asked to identify the priority health needs for children with special health care needs in addition to the populations above. A survey to collect further information on the needs of Montana's children and youth with special health care needs (CYSHCN) from parents and staff is being developed in conjunction with a local pediatrician and is expected to be completed by the end of 2005.

The lists of health needs respondents were asked to select from were based on previous needs assessments and data collection (both in Montana and nationwide), national and state performance measures and health status indicators, and literature reviews. All respondents were asked to indicate the ages of children in their household (in the case of parents) or the ages of children they provide services to (in the case of providers), as well as whether there were pregnant, post-partum or breastfeeding women in their household or clientele (respectively).

Parents were asked whether they or a partner had used prenatal care or breastfeeding help during their most recent pregnancy or birth, domestic violence services during the past 5 years, family planning services during the past 5 years, and if their child or children had received dental care during the past 5 years. Providers were asked to identify the average distance clients would have to travel to reach services to address each of the priority health needs identified.

The distribution of surveys varied widely. WIC clinics were stratified by region of the state (see Montana Health Planning Regions, Appendix E) and the size of the town population where they were located. Twenty surveys were distributed at one or two randomly selected clinics within each stratum. The surveys were distributed to parents at a WIC clinic and parents were asked to return the surveys to a WIC staff person before they left. Each WIC client and staff survey packet included a letter-size envelope that completed surveys could be sealed in for confidentiality prior to returning them to staff. Each WIC agency was sent an addressed, postage-paid envelope in which to return all of the staff and parent surveys.

Because each Head Start agency may coordinate several sites, Head Start agencies were not randomly sampled. Instead, each agency was contacted and asked if they would like to participate in the survey distribution. Those who did received packets of 10-20 surveys (one packet for each site), depending on the level of parent participation. Surveys were distributed at one-on-one parent meetings, home visits and general parent meetings. Parents were asked to return the survey to Head Start staff prior to the end of the meeting or home visit. Included with the survey packets for each parent and staff was a letter-size envelope for them to seal completed surveys in before returning them to Head Start staff. Each Head Start agency was provided with a pre-stamped, addressed envelope in which to return the surveys.

Lists of family practice providers, OB/GYNs and pediatricians within the state were derived from licensing lists maintained by the state. Physicians with only specialty licenses, such as child psychiatry, or inactive licenses were deleted from the mailing list. Providers were then stratified by region and location size and five providers (or as many as possible if fewer than five were in the stratification) were randomly sampled from each stratum for the initial mailing. The response to the first mailing was minimal, so a second mailing went out to an expanded list of physicians. Follow-up surveys were also sent out to those who had not responded to the first mailing. A pre-addressed, stamped envelope was included with each survey sent out.

The school nurse mailing list was compiled from previous mailing lists, school district lists, and the Montana Association of School Nurses membership list. Because the finalized list of school nurses likely contained some out-of-date information and some individuals who did not provide regular school health services, surveys were mailed to all names on the list, instead of sampling by region and location size. A question was also added to the school nurse survey asking respondents to indicate whether they provide health services in a school setting. Follow-up surveys were sent to those who did not

respond to the first mailing. A pre-addressed, stamped envelope was included with each survey sent out.

Montana has two youth correctional facilities. Health staff at both facilities were contacted and surveys were distributed to all of the health staff. A pre-addressed, stamped envelope was included with each survey sent out.

Of Montana's 56 counties, 54 contract with the state for MCH Block Grant funds. One of the counties' contractual requirements is to complete an annual pre-contract survey. This year, the needs assessment survey was incorporated into the pre-contract survey and sent out to the 52 counties that were contracting with the state for MCHBG funds at the time of the mailing. The shorter provider surveys were mailed out to the remaining four counties. All but one of the counties returned the completed survey. Additional questions on the county PHN survey covered MCH services provided by the county. Topics included home visiting services, school health services, domestic violence screening and referrals, and state and national performance measure and health status indicators being tracked.

As mentioned above, a CYSHCN-specific needs assessment survey is currently in development and will be disseminated to parents of CYSHCN and staff and physicians who provide services by October of 2005. The FCHB is partnering with a local pediatrician to design and distribute the survey. Respondents will be asked to select the priority health needs from the same list used on the survey sent to PHNs, and will also be asked questions related to medical home, and use of and access to services and resources for themselves and their families.

Analysis and Limitations

Analysis of the data was conducted using SPSS Version 12.0. In most cases, simple frequencies or crosstabulations were used to summarize results. To assess the needs identified for each population group, the responses for each group were recoded and analyzed as a set. Analysis of the survey results will continue in order to provide detailed and useful summaries and analyses to state partners and to inform the FCHB strategic planning activities.

Estimates of respondent populations within the state were not accurate enough to allow weighting of results. Reliable lists of practicing providers within the state were not available, and numbers of parents or families participating in WIC and Head Start (as opposed to child and individual participants) are not collected. Consequently, respondent results were stratified by region of the state to allow any regional differences in needs and responses to emerge. In addition, because the size of a town's population and proximity to larger population centers or specific care providers, such as IHS facilities, can affect access to care and potentially influence the prevalent health needs, results were stratified by the size of the town population and location. The population/location strata are:

- 1 - 0-2,000 population
- 2 - 2,001-10,000 population
- 3 - >10,000 population

4 - Reservation

5 - Location within 30 miles of a >10,000 population town

Population/locations stratification definitions were determined by comparing attributes of towns throughout the state that fall within each population range to try to include those with similar health resources in the same location groups. For instance, Kalispell (2000 population 14,223) is the only town in the state with a population between 8,487 (Miles City) and 25,780 (Helena). It was included with the “larger” cities because the health outcomes, providers and health resources available in the community were more similar to Helena and Butte (population 33,892) than to Glendive (4,729) and Miles City. As with any categorization, however, the dividing line between one category and another is not always clear-cut, and the large ranges may mask subtle differences between one strata and the next. Also, the numbers of respondents were not high enough to allow for stratification by both region and location size. Instead, to ensure that both the regions and various populations were represented, we stratified first by respondent type and region and recorded the priority needs that emerged for each group, then stratified by respondent type and population/location, recorded the health needs again and compared the two sets of results.

The populations of Montana residents surveyed for the needs assessment represent a limited segment of Montana’s population. WIC and Head Start parents may be more likely to be linked with public health resources through the WIC and Head Start programs than parents who are not connected with similar programs. The parents represented in the survey results might therefore be less likely to have difficulty finding out about and linking to available services than unrepresented segments of the population. Alternatively, both WIC and Head Start programs have income eligibility requirements, which results in parent responses that represent a low-income segment of the Montana population. A lower income level may influence the health needs identified by families because of difficulties encountered in accessing and paying for care.

Slight changes in priority lists on the distributed surveys resulted in some groups having different choices of priority needs. Because county public health nurses were asked to specifically select needs for CSHCN, the “Clinics for children with special health care needs, such as a disability” priority need was not included in their lists for infants and young children and children. Also, because counties that receive MCH BG funds were required to complete the survey, their surveys were longer and slightly different from other respondents. However, the changes were primarily for one group of respondents, and do not appear to significantly alter the identified lists of priorities.

The distribution of surveys was not standard across all groups, nor was there random selection of respondents or respondent agencies in for all types of respondents. In cases where the initial list of respondents was known to be incomplete or inaccurate, surveys were sent to all possible respondents (in the case of school nurses) or all agencies were contacted regarding distribution of the surveys (in the case of Head Start). For the parent respondents, distributing surveys through the agencies was both an advantage and disadvantage. By distributing surveys through a second party FCHB had less control

over how the surveys were disseminated, and thus could not ensure that all surveys were distributed and that distribution was random. Also, because surveys were sent out in bulk, a lack of response from one agency (due to unexpected events, low parent participation or loss of surveys in the mail system) resulted in under-representation or a lack of representation for that location stratum.

However, the advantages of working with WIC and Head Start Agencies far outweighed the drawbacks. The majority of agencies were very willing and interested in participating in the needs assessment, and their assistance with survey distribution ensured that client perspectives were represented in the needs assessment. Had we not partnered with the WIC and Head Start agencies, collecting parent and client responses would have been much more time consuming and costly, and the response rate most likely would not have been as high.

Respondent Demographics

Respondent Type	Number of Surveys Returned	Number of Surveys Sent	Response Rate (Among those Who Were Sent Surveys)
Head Start parents	339	705	48.1%
Head Start staff	65	92	70.7%
WIC parents/participants	310	420	73.8%
WIC staff	34	46	73.9%
County public health nurses	53	56	94.6%
School nurses	87 (119)*	178*	66.9%
Family practice providers	92 (100)	310**	32.3%
OB/GYNs	35 (36)	106**	34.0%
Pediatricians	47 (51)	108**	47.2%
Corrections staff	2	7	28.6%
TOTAL	1064 (1109)	2028	54.7%

* An unknown number of addresses on the school nurse mailing list did not represent school nurses. The number in parenthesis is the actual number of surveys returned, regardless of whether the respondent was a school nurse or not. The other number represents only individuals currently providing health services in a school setting and thus included in the analysis. The number in parenthesis is used to calculate the response rate.

**A number of providers called or returned surveys and indicated that they are retired or not currently practicing medicine in Montana. The number in parenthesis is the total number of surveys returned; the other number is the total of currently practicing physicians (and those who did not indicate they are retired or not practicing in Montana) who returned surveys. The number in parenthesis is used to calculate the response rate.

Survey Respondents by Regions of Montana						
	Region					
	1	2	3	4	5	NA
Head Start parent	39	93	20	28	159	
Head Start staff	7	22	9	9	18	
WIC parent	43	41	68	66	92	
WIC staff	6	5	8	6	9	
County public health nurse	15	9	10	12	7	
School nurse	12	4	15	26	30	
Family practice provider	7	17	21	29	18	
OB/GYN	5	7	5	6	12	
Pediatrician	3	11	11	9	13	
Corrections						2

TOTAL	137	209	167	191	358	2
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Survey Respondents by Population or Location						
	Town Population/Location					
	0-2,000	2,000-10,000	10,000+	Reser- vation	Within 30 miles of 10,000+ town	NA
Head Start parent	62	75	65	85	52	
Head Start staff	6	9	21	26	3	
WIC parent	71	77	66	51	45	
WIC staff	10	7	9	7	1	
County public health nurse	23	18	7	2	3	
School nurse	18	8	28	12	21	
Family practice provider	21	20	33	5	13	
OB/GYN	0	8	24	1	2	
Pediatrician	2	5	35	1	4	
Corrections						2
TOTAL	213	227	288	190	144	2

Eighty-five percent of respondents either provide services to or reside in a household with a child five years old or younger. Forty-five percent provide services or reside in a household with a child age 6 to 11 years. Thirty-eight percent provide services or reside in a household with a youth aged 12 to 21 years. Sixty-six percent of respondents reside in a household with or provide services to women who are pregnant or have recently had a child.

Survey Results

The priority health needs according to regions of the state were markedly similar to the priority health needs by population size and location. The lists of health needs for each population below were compiled by noting the most frequently selected health needs among each respondent group, according to both regional location and population size of the town where the respondent is located.

Needs that consistently emerged as priorities for **infants and young children**, when results were analyzed by both respondent group and region and respondent group and location stratification, were:

- Access to dental care
- Access to health care
- Health insurance
- Child abuse and neglect services
- Safe and affordable child care

Mental health services and immunizations were also frequently identified as priority health needs for infants and young children.

Needs that consistently emerged as priorities for **children**, when results were analyzed by both respondent group and region and respondent group and location stratification, were:

- Access to dental care
- Access to health care
- Health insurance
- Child abuse and neglect services
- Obesity
- Mental health

Safe and affordable access to childcare was also frequently identified as a priority health need for children.

Needs that consistently emerged as priorities for **adolescents**, when results were analyzed by both respondent group and region and respondent group and location stratification, were:

- Alcohol and drug abuse prevention and treatment
- Access to dental care
- Pregnancy prevention
- Mental health services
- Health insurance
- Access to health care

Sexual health education, tobacco use prevention and treatment and obesity prevention were also frequently identified as priority health needs for adolescents.

Needs that consistently emerged as priorities for **women**, when results were analyzed by both respondent group and region and respondent group and location stratification, were:

- Birth control
- Parenting education
- Health insurance
- Access to health care
- Mental health/postpartum depression services

Alcohol and drug abuse prevention and treatment, access to dental care and tobacco use prevention and treatment were also frequently identified as priority health needs for women.

A survey of CYSHCN parents and providers is ongoing, and currently only results on priority needs are available from the county public health nurse (PHN) surveys. PHNs indicated that the priority health needs for **CYSHCN** were:

- Access to dental care
- Access to health care
- Clinics to address the special needs of children
- Mental health services
- Respite care for parents and caregivers

- Health insurance

Not surprisingly, respondents in location stratification 1 (2,000 population or less) were more likely to indicate that they had to travel more than one hour's drive to reach services to address their health needs.

Head Start and WIC staff were more likely than parents to identify services for CYSHCN as a priority. Parents with CYSHCN may either not consider their children to be CYSHCN, believe that all special needs for their child are met, or that more basic health needs take precedence over specialized services for CYSHCN. Similarly, providers more commonly identified mental health services as a need than parents. It may be that staff and providers are trained to recognize signs of mental health needs in the clients, whereas parents may not classify signs of mental health need as such. Alternatively, staff and providers may be more aware of the lack of mental health services within the state, and be more likely to identify it because they know it to be an established need within the state.

Among the parent respondents, 89.7% indicated that they or their partner received prenatal care during their last pregnancy. Sixty-one percent traveled less than ½ hour's drive to receive care, 26.7% traveled ½ hour to 1 hour's drive and 12.3% traveled more than 1 hour's drive to receive prenatal care.

The most common reason selected for not using prenatal care was that it wasn't needed, followed by inability to afford the cost of services and not having insurance coverage.

Over 50% of parent respondents reported that they did receive help with breastfeeding during their or their partner's most recent pregnancy. Of those who received breastfeeding support services, 73.8% accessed services within ½ hour's drive of their home, 17.2% had to drive between ½ hour and 1 hour to receive services, and 9% had to drive more than an hour. Not breastfeeding and not needing help with breastfeeding were the most common reasons why parents responding to the survey did not receive help with breastfeeding. Seventeen respondents (2.8%) indicated that they did not use breastfeeding assistance because they did not know where to find help with breastfeeding.

Just under 12% of parents who responded to the survey received domestic violence services during the last 5 years. Those who used domestic violence services were asked to identify the services they received that were within one hour's drive of their residence. Over 56% of the parents who received domestic violence services used counseling services, 53.9% received law enforcement intervention, 31.6% received legal aid, and 19.7% received shelter services.

Fifty-three percent of WIC and Head Start parents who participated received family planning services within the last five years. Seventy-one percent of those parents could reach family planning services in less than ½ hour's drive, 19.9% had to drive ½ hour to 1 hour, and 8.4% had to drive more than one hour to reach family planning services.

Among those who did not use family planning services, 68.9% indicated they did not need family planning services, 4.2% cited cost of services as one of the reasons, 4.2% did not know where to find family planning services, 2.1% did not have child care for their other children, and 2.1% noted that family planning services were too far away.

Seventy-two percent of WIC and Head Start parents had taken their child or children to a dentist within the last five years. Sixty-five percent of parents traveled less than ½ hour, 23.6% traveled ½ hour to 1 hour's drive, and 11.5% traveled more than 1 hour's drive for their children to receive dental services. Most commonly cited reasons for not receiving dental care were a lack of need, inability to afford services, lack of insurance coverage, and inability to find a dental provider.

IV. MATERNAL AND INFANT HEALTH

Birth Rate
Age of Mother at Time of Delivery
Prenatal Care
Medical Risk Factors
Tobacco Use
Alcohol Use
Illicit Drug Use
Domestic Violence
Method of Delivery and Obstetric Procedures
Complications of Labor and/or Delivery
Period of Gestation
Low Birth Weight
Multiple Births
Abnormal Conditions of Newborn
Breastfeeding
Reproductive Health
Induced Abortion
Sexually Transmitted Diseases
HIV/AIDS
Maternal Mortality
Fetal Deaths
Infant Mortality
SIDS

STAKEHOLDER SURVEY RESULTS

Needs that consistently emerged as top priorities for these MCH populations included:

Infants and young children

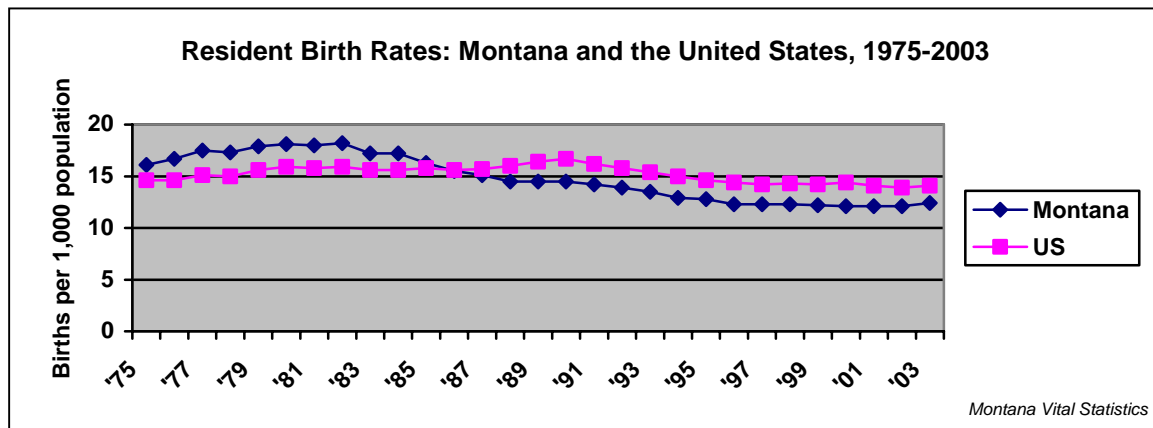
Access to dental care
Access to health care
Health insurance
Child abuse and neglect services
Safe and affordable child care

Women

Birth control
Parenting education
Health insurance
Access to health care
Mental health/postpartum depression services

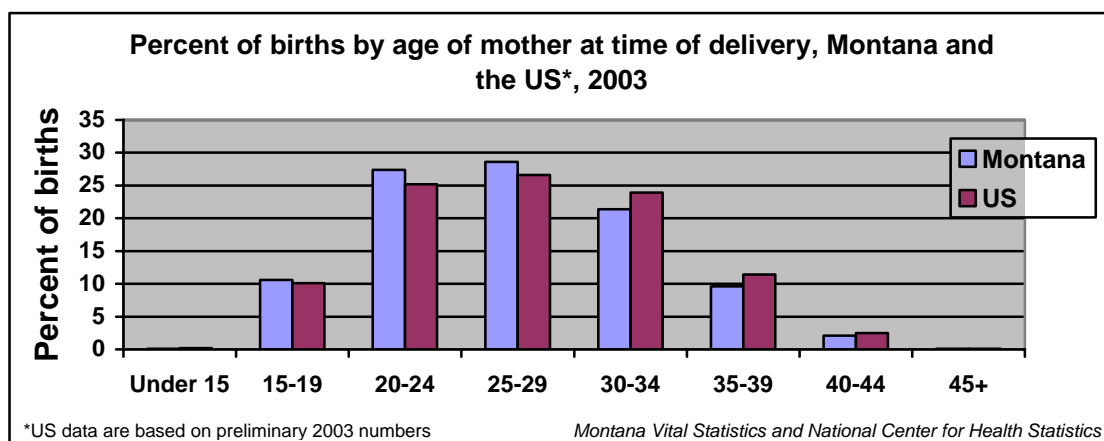
Birth Rate

Montana's birth rate has been steadily declining since the early 1980s, and has consistently been lower than that of the nation as a whole since the mid 1980s.⁷ The Montana birth rate for 2003 was 12.4 per 1,000 population, compared to a US rate of 14.1. From 2000 to the end of 2003 the average annual number of births in Montana was 11,086.



Age of Mother at Time of Delivery

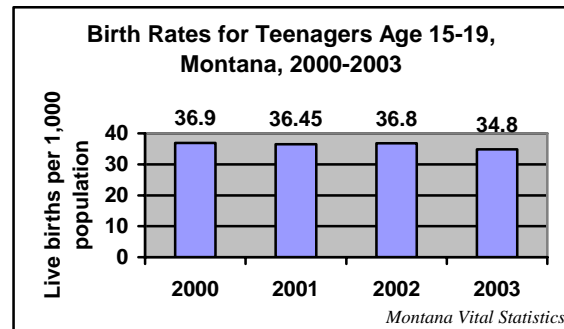
Women in Montana tend to be younger than their national counterparts when they give birth. Similar to the US population, the highest percentage of births in Montana occur to women 25 to 29 years of age, however, in 2003 66.7% of women in Montana who gave birth were under age 30, compared to 62.1% of women throughout the US. Just over 2% of Montana births in 2003 were to women over 40 years of age. The percentage of US births to women over 40 was similar, at 2.6%.



⁷ Montana Vital Statistics, 2003. Office of Vital Statistics, Montana Department of Public Health and Human Services. December 2004.

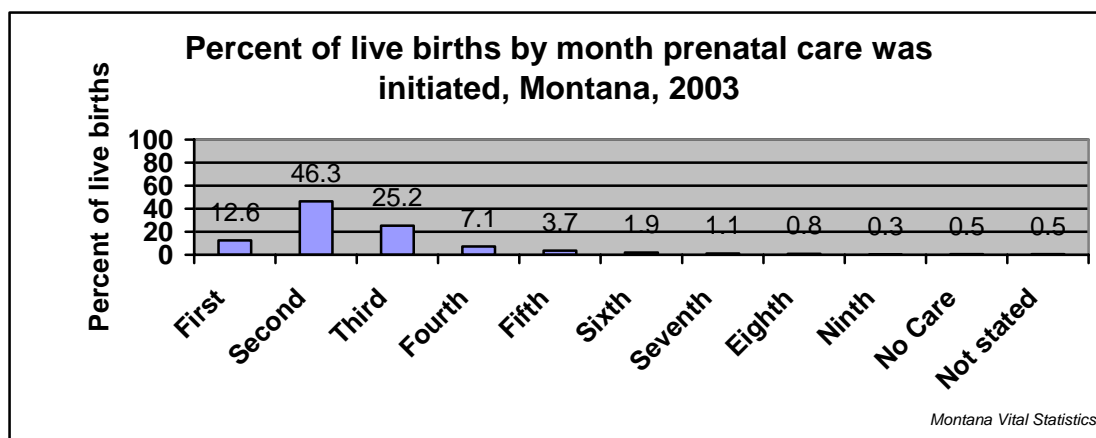
The 2003 Montana teen birth rate (births per 1,000 teenagers ages 15-19) was 34.8 per 1,000 teens compared to 41.7 per 1,000 teens nationally⁸. There were a total of 1,202 births to women aged 15-19 years old in 2003, 1,280 births in 2002, 1,275 births in 2001, and 1,273 births in 2000.

Pregnancies among 15-17 year olds in Montana have been decreasing since 2000. In 2000, there were 18.6 teen pregnancies age 15-17 per 1,000 pregnancies. In 2001, there were 17.6 teen pregnancies age 15-17 per 1,000 pregnancies. In 2002, there were 17.4 teen pregnancies age 15-17 per 1,000 pregnancies. The Healthy People 2010 objective for adolescent pregnancies is 43 per 1,000 females aged 15 to 17 years.



Prenatal Care

In 2003, 84.1% of pregnant women in Montana received prenatal care in their first trimester of pregnancy, compared to 84.1% nationally (preliminary 2003 results). In Montana, 2.6% of pregnant women began prenatal care in their third trimester or received no prenatal care, versus 3.5% of women throughout the United States. The Healthy People 2010 objective for pregnant women receiving prenatal care that begins in the first trimester of pregnancy is 90% of live birth.



Medical Risk Factors

The most common medical risk factors occurring in Montana from 2000-2003 were pregnancy-related hypertension, gestational diabetes, anemia, previous preterm or small for gestational age infant, hydramnios/oligohydramnios and genital herpes.

⁸ Births: Preliminary data for 2003. Accessed at http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_09.pdf. 6/23/05.

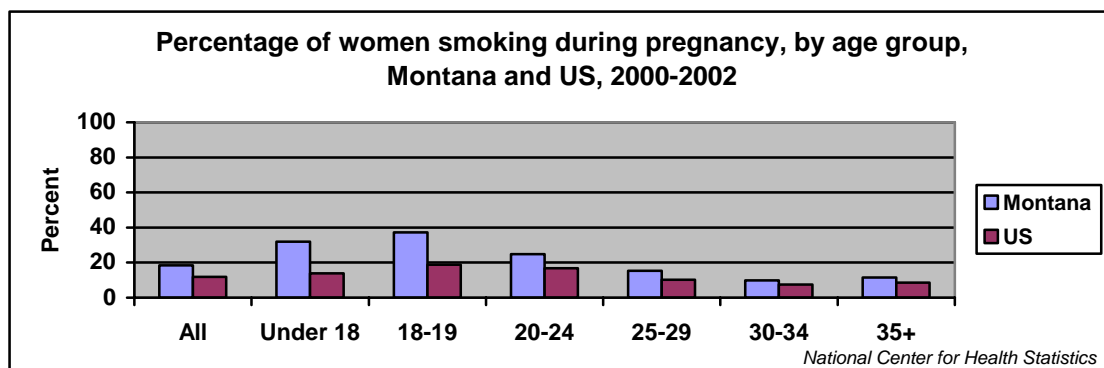
Percentage of Live Births to Mothers with Reported Medical Risk Factors Montana, 2000-2003

	2000	2001	2002	2003	Total
	%	%	%	%	%
No Medical Risk Factors	67.0	65.1	64.2	64.4	65.2
Anemia	1.5	1.8	2.0	1.7	1.8
Cardiac Disease	0.2	0.2	0.1	0.2	0.1
Acute or Chronic Lung Disease	0.3	0.2	0.1	0.2	0.2
Gestational Diabetes	2.1	2.3	2.3	2.3	2.2
Non-Gestational Diabetes	0.6	0.4	0.5	0.5	0.5
Genital Herpes	1.3	1.1	1.1	1.2	1.2
Hydramnios/Oligohydramnios	1.0	1.4	1.2	1.5	1.3
Hemoglobinopathy	0.05	0.01	0	0.01	0.01
Chronic Hypertension	0.5	0.5	0.5	0.5	0.5
Hypertension, Pregnancy-Related	5.2	5.3	5.0	4.5	5.0
Eclampsia	0.5	0.5	0.5	0.4	0.5
Incompetent Cervix	0.3	0.4	0.4	0.3	0.3
Previous Infant 4,000 Grams	1.3	1.0	0.9	0.8	1.0
Previous Preterm or Small for Gestational Age Infant	1.7	1.5	1.4	1.2	1.5
Renal Disease	0.1	0.1	0.1	0.1	0.1
RH Sensitization	0.6	0.4	0.5	0.8	0.6
Uterine Bleeding	0.7	0.5	0.6	0.6	0.6
Other Risk Factors	21.1	23.2	24.4	24.4	23.3

Montana Vital Statistics

Tobacco Use

An estimated 28.1% of women in Montana smoked in 2001-2003.⁹ Montana women, particularly those 19 and younger, are more likely to smoke during pregnancy than their national counterparts. According to 2000-2002 data from the National Center for Health Statistics, 18.4% of Montana women smoked during pregnancy, compared to 11.9% of pregnant women throughout the United States. The Healthy People 2010 objective for tobacco use during pregnancy is 99% abstinence from tobacco use during pregnancy.



⁹ National Center for Health Statistics, 2001-2003 data.

<http://209.217.72.34/healthywomen/TableViewer/tableView.aspx?ReportId=162>. Accessed 7/11/05.

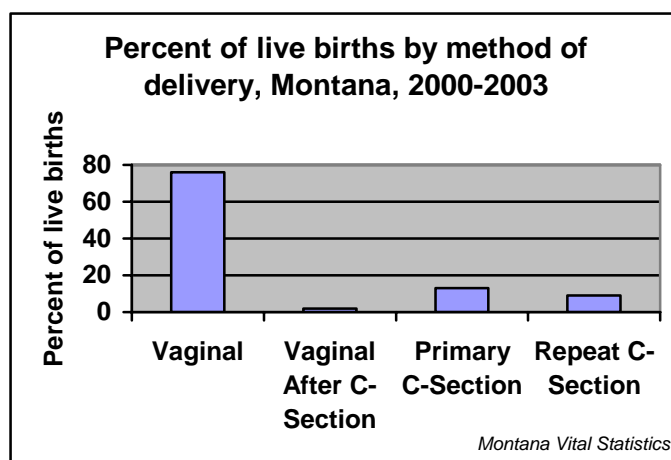
Disparities exist in Montana's rate of smoking during pregnancy by race/ethnicity as well as age. Almost 10% of Asian and Pacific Islander women in Montana who were pregnant during 2000-2002 smoked during pregnancy, compared to 17% of white women, 19% of black women, and 29.7% of Native American women.

Alcohol Use

The Healthy People 2010 objective for alcohol use during pregnancy is to increase abstinence from alcohol to 94% in all pregnant women. Results from the 2002 Pregnancy Risk Assessment Monitoring System (PRAMS) point-in-time estimate for Montana indicate that 17.9% of women did not drink, and 42.7% of women averaged less than one drink per week three months prior to pregnancy. During the last three months of their pregnancy, 91.5% of women reported no drinking, 7.1% reported averaging less than one drink per week, and less than 1% reported drinking an average of one or more drinks per week.

Method of Delivery and Obstetric Procedures

In 2003, 97% of births in Montana took place in hospitals and 2.4% took place outside of a hospital and were attended by someone other than a physician. The rate of cesarean sections in Montana for 2003 was 24 per 100 live births, compared to a preliminary 2003 US rate of 27.6 per 100 live births. The Healthy People 2010 objective is to reduce first time cesarean section deliveries to no more than 15% of all live births. The percent of deliveries in Montana that are first-time cesarean sections was less than 15% for 2000, 2001, 2002 and 2003.



During the 2000-2003 period, electronic fetal monitoring was reportedly used for 92% of births and ultrasound was used for 83% of births. Twenty-seven percent of labors were induced and 17.6% of labors were stimulated. Amniocentesis was performed for 2.5% of births.¹⁰

Complications of Labor and/or Delivery

More than 30% of all Montana births from 2000 through 2003 had at least one complication during labor and delivery. The most common complications were fetal distress, breech/malpresentation, and moderate to heavy meconium.

Percentage of Births with Complications of Labor and/or Delivery Montana 2000-2003

2000	2001	2002	2003	TOTAL
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¹⁰ Reported Obstetric Procedures. Office of Vital Statistics, Montana Department of Public Health and Human Services. 2000-2003 data.

	%	%	%	%	%
No Complications	66.4	67.5	65.1	65.8	66.2
Maternal Fever (Febrile)	0.7	0.6	0.7	0.5	0.6
Meconium, Moderate to Heavy	3.5	3.1	3.5	3.5	3.4
Premature Rupture of Membrane	2.6	2.2	2.1	2.2	2.3
Abruption Placenta	0.8	0.6	0.6	0.7	0.7
Placenta Previa	0.3	0.3	0.3	0.2	0.3
Other Excessive Bleeding	0.8	0.7	0.8	0.7	0.8
Maternal Seizures During Labor	0.04	0.02	0.03	0.02	0.03
Precipitous Labor (< 3 hours)	2.8	2.7	2.7	3.1	2.8
Prolonged Labor (> 20 hours)	1.0	0.7	0.9	0.7	0.8
Dysfunctional Labor	1.9	2.1	2.5	2.1	2.1
Breech/Malpresentation	3.8	4.0	3.7	3.7	3.8
Cephalopelvic Disproportion	1.3	1.3	1.3	1.2	1.3
Cord Prolapse	0.2	0.1	0.2	0.1	0.1
Anesthetic Complications	0.05	0.04	0.04	0.03	0.04
Fetal Distress	3.8	4.1	4.1	3.2	3.8
Other Complications	18.5	18.4	19.6	19.7	19.1

Montana Vital Statistics

Period of Gestation

In 2003, 9.4% of births were at less than 37 weeks of gestation in Montana. The Healthy People 2010 objective is to reduce total preterm births to no more than 7.6% of all live births.

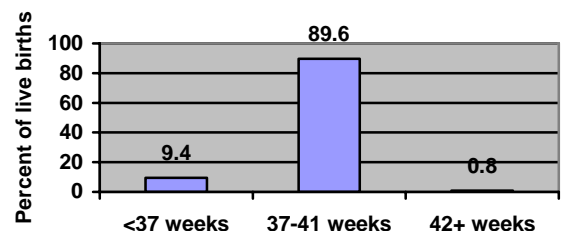
Low Birth Weight

In 2003, 6.7 % of the babies born in Montana had birth weights of less than 2,500 grams. In the US in 2003, 7.8 % of babies were of low birth weight. Montana's rate of low birth weight births has trended to increase since 1991.¹¹ From 1999-2001, 1.1% of all births in Montana were classified as very low birth weight (VLBW), or less than 1,500 grams, compared to 1.4% nationally. The Healthy People 2010 objective is for no more than 5% of all live births to be of low birth weight.

Multiple Births

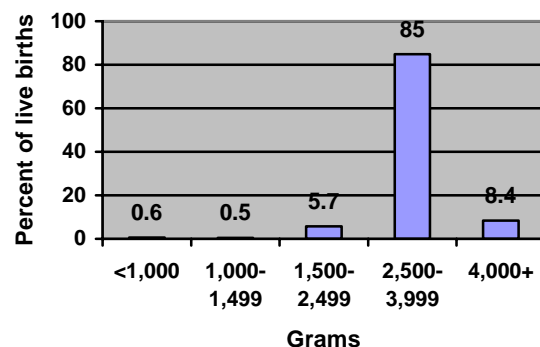
Montana has experienced an increase in twin births since 1998. Triplets or more have varied each year. In 2002,

Percent of live births by completed weeks of gestation, Montana, 2003



Montana Vital Statistics

Percent of live births by birthweight, Montana, 2003



Montana Vital Statistics

¹¹ Montana Vital Statistics, 2003. Office of Vital Statistics, Montana Department of Public Health and Human Services. December 2004.

97% of all Montana births were single births. Twin births accounted for 2.9% of all Montana births and triplets or more accounted for 0.1% of all Montana births in 2002.

Abnormal Conditions of Newborn

In 2003, just over 6% of infants had at least one abnormal condition reported at birth, or needed assisted ventilation. The three most reported abnormal conditions of a newborn from 2000 through 2003 in Montana were need of assisted ventilation (both over and under 30 minutes), hyaline membrane disease/RDS, and meconium aspiration syndrome.

Percent of Births with Reported Abnormal Condition(s) Montana 2000-2003					
	2000	2001	2002	2003	TOTAL
	%	%	%	%	%
No Abnormalities	93.8	94.5	93.6	93.5	93.8
Infant Anemia	0.2	0.06	0.08	0.07	0.1
Birth Injury	0.1	0.1	0.2	0.2	0.1
Fetal Alcohol Syndrome	0.02	0.01	0.02	0.02	0.02
Hyaline Membrane Disease/RDS	1.3	1.1	1.1	0.6	1.0
Meconium Aspiration Syndrome	0.2	0.2	0.2	0.2	0.2
Assisted Ventilation (<30 min.)	0.9	1.0	1.2	1.1	1.1
Assisted Ventilation (>30 min.)	1.4	1.1	1.3	0.7	1.1
Seizures	0.2	0.1	0.1	0.3	0.2
Other Abnormalities	3.6	3.3	4.2	4.5	3.9

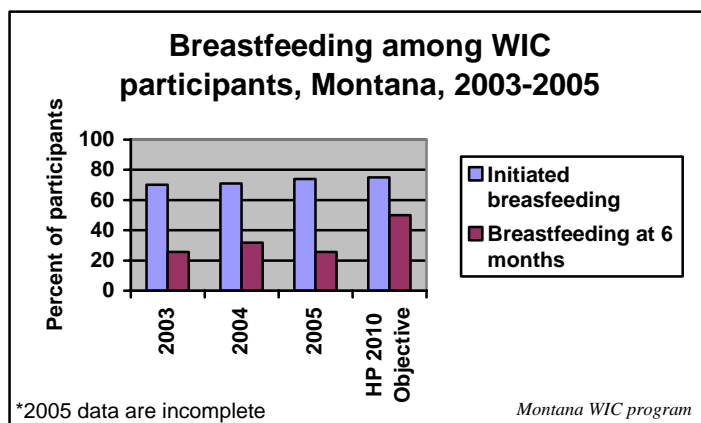
Montana Vital Statistics

Montana vital statistics data for 2000 through 2003 report that no congenital anomalies were identified at birth for 98% of the infants born in Montana during the time period. The most common congenital anomalies reported at birth were: cleft lip/palate (75 infants), heart malformations (61 infants), club foot (54 infants), and Down Syndrome (49 infants). 90% of babies born in Montana during 2003 were screened for hearing loss prior to hospital discharge. Of the newborns screened and reported, 6% did not pass prior to the hospital discharge. Additional newborn screening results for 2000-2001 are listed below.

Percent of Newborns Screened and Numbers of Abnormal Results Montana, 2000-2003				
	2000	2001	2002	2003
Percent Newborns Screened	99	99.1	98.7	96.5
Abnormal Results				
PKU-Initial	1	3	7	6
PKU-Confirmed	0	2	1	2
Galactosemia-initial	2	5	1	2
Galactosemia-confirmed	0	0	0	0
T4/TSH-initial	88	97	121	132
T4/TSH-confirmed	2	3	5	2
Hemoglobinopathies-initial	48	27	48	39
Hemoglobinopathies-confirmed				
Cystic Fibrosis-initial	16	18	9	12

Breastfeeding

According to the 2003 National Immunization Survey, Montana's overall rate of breastfeeding surpasses the Healthy People 2010 objective. Approximately 82.3 % of women in Montana ever breastfeed their child, compared to the Healthy People 2010 objective of 75% of women breastfeeding immediately postpartum. Montana's rate of breastfeeding at 6 months is approximately 44.5 %, which falls just short of the HP 2010 expectation of 50 % breastfeeding at 6 months. 2002 Pregnancy Risk Assessment Monitoring Survey (PRAMS) results show a slightly higher rate of ever breastfeeding – 85.77%. The most commonly cited reasons among PRAMS respondents for not initiating breastfeeding were other children, didn't like breastfeeding and work or school. The most common barriers to continuing breastfeeding were difficulty nursing, milk did not satisfy the infant, not producing milk and work or school.



Data sources for WIC participants indicate a lower rate of breastfeeding than the general Montana population. In 2005, 74% of Montana women participating in WIC breastfed their baby after birth and 25.7% were still breastfeeding at six months. Breastfeeding rates among WIC participants have increased over the past several

years. This difference in rates of breastfeeding from one population group to another is consistent with NIS' findings that socioeconomically disadvantaged groups have lower rates of breastfeeding¹² and reinforces the need for breastfeeding support and education provided by programs such as WIC.

Reproductive Health

According to the Alan Guttmacher Institute, 90,560 Montana women ages 13-44 were in need of contraceptive services and supplies in 2002, or 46 % of the 13-44 year-old population. Women are considered in need if they are sexually active, are able to become pregnant (they or their partner have not had a tubal ligation or vasectomy or have other reason to believe they cannot become pregnant), and are neither intentionally pregnant nor trying to become pregnant. Among women 20-44, 54.4% of women in need reside in households with incomes less than 250 % of the federal poverty level (\$42,250 for a family of four in 2002). Women who fall into this category are considered in need of publicly supported family planning services. The number of women in Montana in need of publicly supported contraceptive services and supplies increased 4.5 % between 1995

¹²National Immunization Survey. http://www.cdc.gov/breastfeeding/NIS_data/. Accessed 6/20/05

and 2000, and has continued to increase since then.¹³ Montana does not have a law requiring insurance companies to provide contraceptive coverage.

Family planning programs throughout the state provide reproductive health, family planning, STD (including HIV), and cancer screening services to women regardless of ability to pay. Providing services in Montana is compounded by the size of the state and distance to services for some residents, as well as the relatively high rate of poverty in the state.

Induced Abortion

The ratio of induced abortions to live births in Montana has been declining since the mid-1990s. In 2003 the ratio was 193.8 induced abortions per 1,000 live births. As states no longer report induced abortions to the National Center for Health Statistics, a comparable national ratio is not available.

Sexually Transmitted Diseases

Chlamydia, gonorrhea and syphilis are the only reportable STDs in Montana. Chlamydia is the most common STD in Montana. Among women of reproductive age, 1052 cases of chlamydia were reported in 2000, 1369 in 2001, 1776 in 2002, 1778 in 2003 and 1848 in 2004. The chlamydia rate among women in Montana has increased since 2000.¹⁴

Women of reproductive age account for approximately 71 % of the reported chlamydia cases in Montana. For gonorrhea, 37 cases were reported among women of reproductive age in 2000, 49 in 2001, 76 in 2002, 70 in 2003 and 51 in 2004. No syphilis cases were reported among any populations in 2000-2003, but a sudden increase occurred in 2004, when 4 cases were reported (none in women of reproductive age).¹⁵ There are no accurate estimates of rates of pelvic inflammatory disease (PID) among women in Montana. Pelvic inflammatory disease (PID) is not a reportable disease in the state and, similar to national estimates, the actual rates are believed to be much higher than the reported rate.¹⁶

The Healthy People 2010 objectives are to reduce chlamydia infections in women ages 15-24 years attending family planning clinics and STD clinics to 3.0%. According to the 2003 Chlamydia Prevalence Monitoring Project Annual Report, 4.8% of women 15-44 years old tested at family planning clinics and 7.3% of women 15-44 years tested at STD clinics in Montana had positive chlamydia test results.¹⁷ In 2003, approximately 10% of

¹³ Alan Guttmacher Institute. Number of women in need of publicly supported contraceptive services and supplies, 1995, 2000 and 2002 – National, Regional and State Summary. <http://www.agi-usa.org/pubs/win/allstates.pdf>. Accessed 6/28/05.

¹⁴ Chlamydia Prevalence Monitoring Project Annual Report, State Profiles. Division of STD Prevention, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention. October 2004. <http://www.cdc.gov/std/chlamydia2003/default.htm>. Accessed 6/29/05.

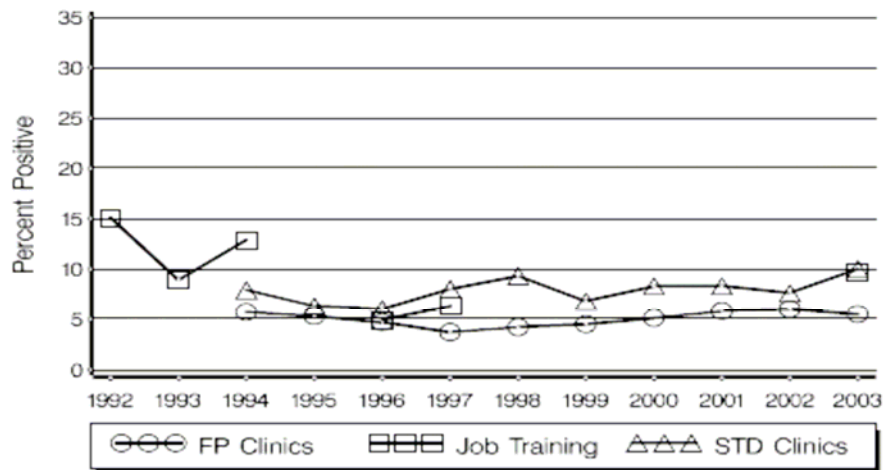
¹⁵ Communicable Disease Control and Prevention, Montana Department of Public Health and Human Services.

¹⁶ Communicable Disease Control and Prevention, Montana Department of Public Health and Human Services.

¹⁷ Chlamydia Prevalence Monitoring Project Annual Report, State Profiles. Division of STD Prevention, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention. October 2004. <http://www.cdc.gov/std/chlamydia2003/default.htm>. Accessed 6/29/05.

women 15-24 tested for chlamydia at STD clinics and just over 5% of women tested at family planning clinics had positive test results.

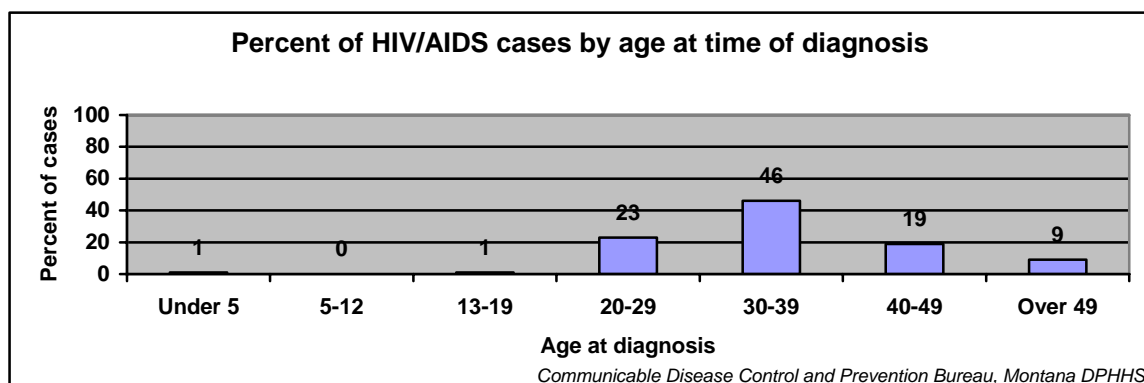
Chlamydia positivity in women 15-24 years by testing site, 1992-2003



Division of STD Prevention, CDC

HIV/AIDS

Between 1985 and December 31, 2004, 633 cases of HIV/AIDS were reported to the Montana Department of Health and Human Services. 268 deaths resulting from HIV/AIDS were reported during the same time period. Eighty-seven percent of the reported HIV/AIDS cases were white, 6% were Native American, 3% were black and 3% were Hispanic. Of the 611 adult cases, 12.5 % were women. The primary means of exposure among women was heterosexual contact, followed by injection drug use (IDU). 6 pediatric cases were reported between 1985 and the end of 2004, 4 of which resulted in death. Among the pediatric cases, 33% were white, 33% were Native American, 17% were black and 17% were Hispanic.¹⁸



¹⁸ Montana HIV/AIDS Cases as of December 31, 2004. Communicable Disease Control and Prevention Bureau, Public Health and Safety Division, Department of Public Health and Human Services.

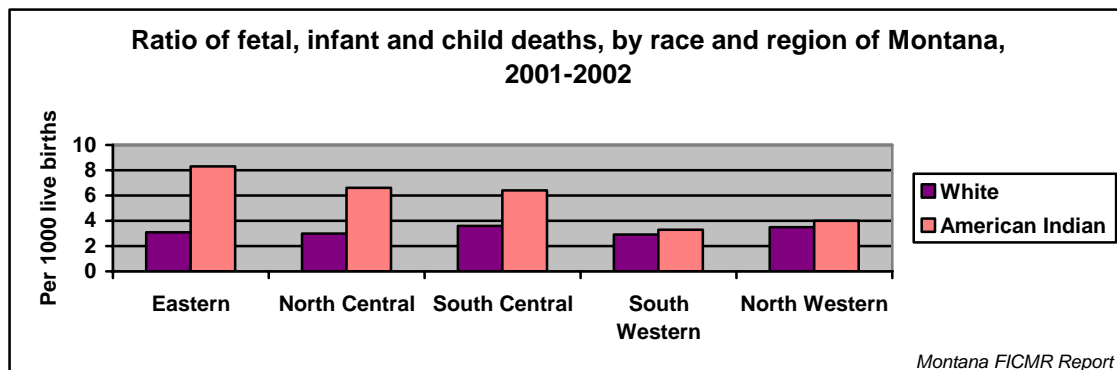
Maternal Mortality

Because Montana has small number of annual births, and maternal mortality is a relatively rare event, the annual maternal mortality rate for the state is not an accurate reflection of the actual state maternal mortality rate. Montana had two maternal deaths each in 2000 and 2001, no maternal deaths in 2002 and five maternal deaths in 2003. A change in reporting requirements in 2003 made it more likely that the death of a woman would be classified as a maternal death, which is likely the reason for the increase in maternal mortality for that year. The ten-year average maternal mortality rate for Montana from 1994-2003 was 10.02 deaths per 100,000 live births. A nine-year study done by the CDC from 1991-1999, showed an average US maternal mortality rate of 11.8 deaths per 100,000 live births. The Healthy People 2010 objective is to reduce maternal mortality to no more than 3.3 per 100,000 live births.

Fetal Deaths

Fetal deaths are required to be reported in Montana if the fetus weighed 350 grams or more, or if the delivery took place after 20 weeks of gestation (if the weight is unknown).

Montana's ratio of fetal deaths in 2003 was 4.8 per 1000 live births. Fifty-five fetal deaths occurred in 2003. Between 2000 and 2003, 204 fetal deaths were recorded in Montana, an average of 51 fetal deaths each year. The Healthy People 2010 objective is to reduce fetal deaths to less than 4.1 deaths per 1000 live births plus fetal deaths. The rate of fetal deaths in Montana in 2003 according to this formula was 4.8 per 1000 live births plus fetal deaths.

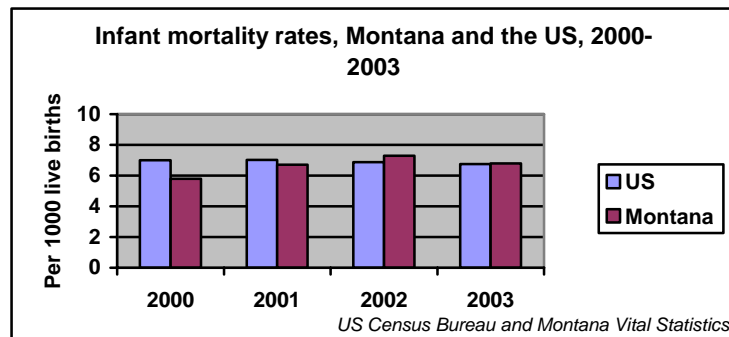


Fetal, Infant and Child Mortality Review (FICMR) teams reviewed 88 fetal deaths in Montana in 2001 and 2002 and determined that 68 had inadequate information to determine preventability and four fetal deaths were preventable.¹⁹ According to the 2002 FICMR report, there is a fairly large disparity between the ratio of fetal, infant and child deaths among Native Americans and deaths among whites, particularly in the eastern portion of the state.

¹⁹ Montana Fetal, Infant and Child Mortality Review, December 2004. Department of Public Health and Human Services. <http://www.dphhs.mt.gov/hpsd/family-health/ficmr/ficmr-index.htm>. Accessed 6/28/05.

Infant Mortality

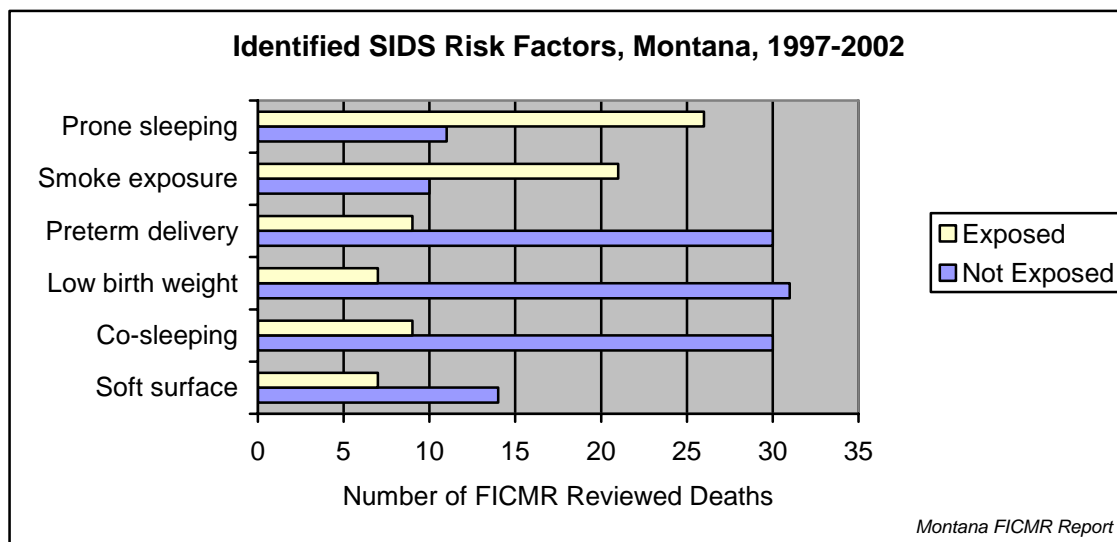
The infant death rate in Montana during 2003 was 6.8 per 1000 live births. 77 infant deaths occurred during 2003. 294 infant deaths were recorded in Montana between 2000 and 2004, an average of 73.5 deaths annually.



Sudden Infant Death Syndrome

In 2001 and 2002, 20 deaths in Montana were listed on death certificates as due to SIDS. The Healthy People 2010 Objective is to reduce SIDS mortality to no more than 0.25 deaths per 1000 live births. Montana has had an average of 10 SIDS deaths per year between 1997 and 2002, and an average of 10891 live births per year for the same time period, resulting in an estimated SIDS mortality rate of 0.92 deaths per 1000 live births. The SIDS rate among Native American infants in Montana is approximately 2.8 times higher than for the rate among their white counterparts.

Fetal, Infant and Child Mortality Review (FICMR) teams reviewed 32 SIDS or “other applicable infant deaths” in 2001 and 2002 and found that many had risk factors associated with SIDS deaths, including sleeping on their stomach (prone sleeping) and exposure to cigarette smoke. Mothers of SIDS infants also had a lower average age than mothers of infants deceased due to other causes.²⁰



²⁰ Montana Fetal, Infant and Child Mortality Review, December 2004. Department of Public Health and Human Services. <http://www.dphhs.mt.gov/hpsd/family-health/ficmr/ficmr-index.htm>. Accessed 6/28/05.

V. CHILD AND ADOLESCENT HEALTH

Child Mortality
Injury and Violence
Family Violence
Motor Vehicle Crashes
Suicide
Childhood Cancer
Immunization and Vaccine-Preventable Diseases
Physical Activity and Obesity
Diabetes
Asthma
Lead Poisoning
Oral Health
Mental Health
Reproductive Health
Sexually Transmitted Diseases
HIV/AIDS
Tobacco Use
Alcohol Use
Illicit Drug Use

STAKEHOLDER SURVEY RESULTS

Needs that consistently emerged as top priorities for these MCH populations included:

<i>Infants and young children</i>	<i>Children</i>	<i>Adolescents</i>
Access to dental care	Access to dental care	Alcohol and drug abuse prevention and treatment
Access to health care	Access to health care	Access to dental care
Health insurance	Health insurance	Pregnancy prevention
Child abuse and neglect services	Child abuse and neglect services	Mental health services
Safe and affordable child care	Obesity	Health insurance
	Mental health	Access to health care

Child Mortality

Leading causes of death, ages 1 to 24, Montana, 2000-2002

Leading causes of death, ages 1 to 24, Montana, 2000-2002					
Rank	Age Groups				
	1-4	5-9	10-14	15-19	20-24
1	Unintentional Injury 16	Unintentional Injury 25	Unintentional Injury 25	Unintentional Injury 113	Unintentional Injury 104
2	Congenital Anomalies 6	Malignant Neoplasms 10	Suicide 9	Suicide 30	Suicide 37
3	Homicide 4	Homicide 5	Congenital Anomalies 3	Homicide 7	Homicide 16
4	Heart Disease 3	Congenital Anomalies 2	Homicide 2	Malignant Neoplasms 7	Malignant Neoplasms 14
5	Influenza and Pneumonia 3	Heart Disease 1	Multiple Causes	Heart Disease 3	Multiple Causes

WISQARS, National Center for Injury Prevention and Control²¹

Injury and Violence

Between 2000 and 2002, unintentional injuries were the leading cause of death among children and youth ages 1-24 years. During the same time period, homicide was the third leading cause of death for children ages 1-9 and youth aged 15-24 and the fourth leading cause of death for 10-14 year olds. Homicide was the cause of death for 46 children and youth between the ages of 1 and 24 during 2000-2003.

The 2003 Youth Risk Behavior Survey (YRBS) results indicate that Montana students generally feel safer at school and are less likely to be threatened with violence or engage in a fight at school than their national peers. However, Montana youth were more likely to have frequent access to firearms than other US teens, and a higher percentage of Montana teens were intentionally physically hurt by a boyfriend or girlfriend.

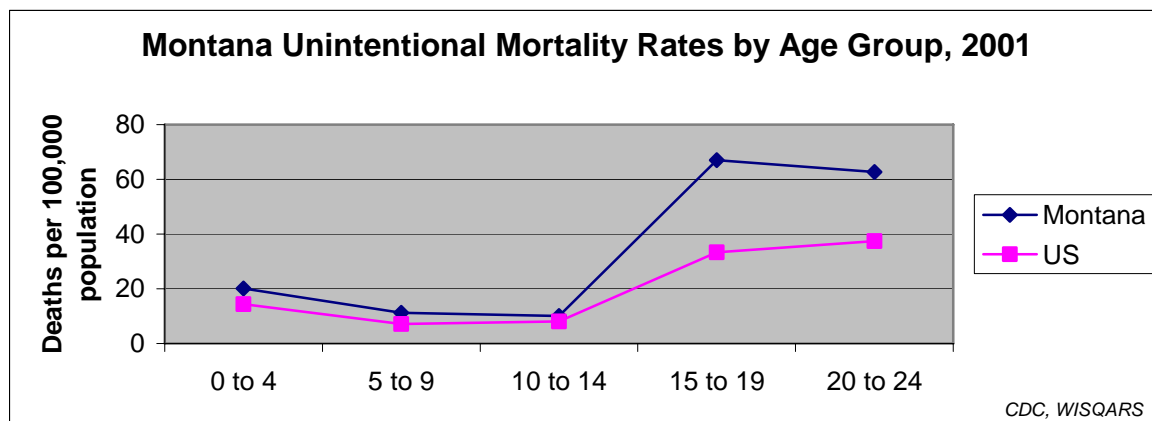
The Healthy People 2010 objective is to reduce physical fighting among adolescents to 32%. According to the 2003 YRBS, 28.6% of Montana teens were in a physical fight one or more times during the previous 12 months.

Youth and Violence Montana and US, 2003 YRBS		
	MT	US
	%	%
Threatened/injured with a weapon at school	7.1 (±0.9)	9.2 (±1.5)

²¹WISQARS, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. <http://webappa.cdc.gov/sasweb/ncipc/leadcaus.html>. Accessed 6/22/05

Did not go to school because they felt unsafe there or on they way to and from	3.4 (± 0.7)	5.4 (± 0.8)
Physical fight on school property one or more times, past 12 months	10.3 (± 1.3)	12.8 (± 1.5)
Carried a gun one or more days, past 30 days	8.7 (± 1.1)	6.1 (± 1.1)
In a physical fight 1 or more times, past 12 months	28.6 (± 2.3)	33 (± 1.9)
Physically hurt by boyfriend/girlfriend, past 12 months	11.7 (± 1.7)	8.9 (± 0.9)

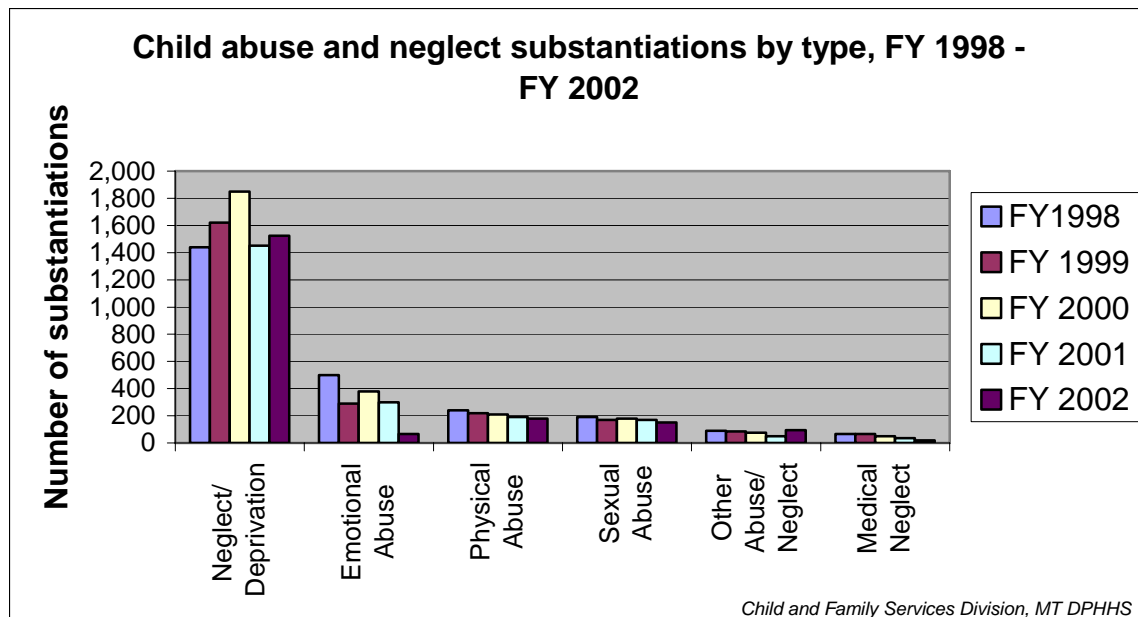
Montana children and adolescents have higher age-specific injury death rates than the United States does as a whole, particularly for the 15-19 and 20-24 age groups.



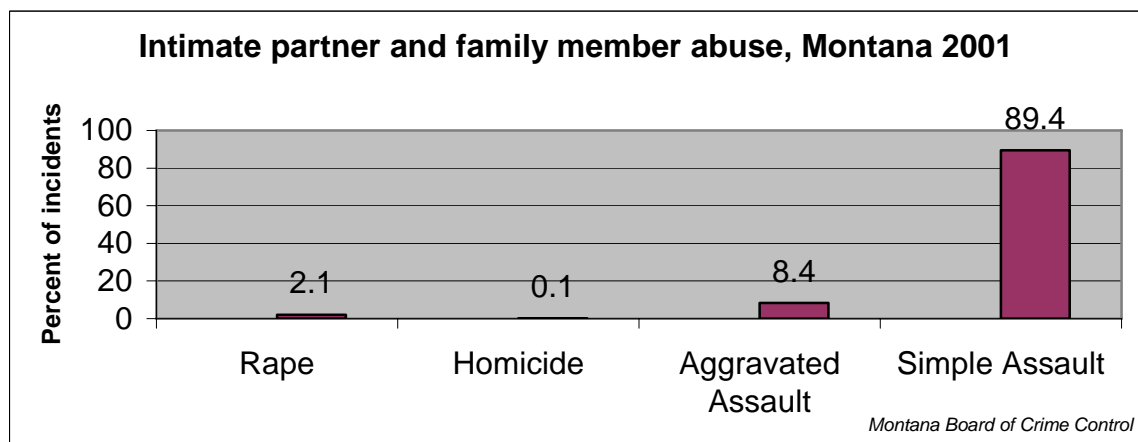
Family Violence

In 2002, there were 24,282 calls placed to Child Protective Services, there were 16,965 reports entered, from these, 10,473 investigations were launched, and 1,466 placements took place. The Healthy People 2010 objective is to reduce the maltreatment of children to 10.3 per 1,000 children under the age of 18 and to reduce the number of child maltreatment fatalities to no more than 1.4 per 1,000 children under the age of 18.

Partner and family member abuse has increased from 1988 to 2001, with 649.8 offenses per 100,000 in 2001 and 172.5 offenses per 100,000 in 1991 in Montana. Simple partner and family member abuse was 435.5 per 100,000 in 2001 and 391.2 per 100,000 in 2000, indicating an 11.3% increase. In 2000 the arrest clearance rate for simple partner and family member abuse was 57.3% and in 2001 the arrest clearance rate for simple partner and family member abuse was 58.9%, an increase of 2.7%, according to the Montana Crime Control Board.



Partner and family member related offenses comprised at least 22.5% of all aggravated assaults and 21.7% of all rapes in 2001 according to the Montana Board of Crime Control.



Motor Vehicle Crashes

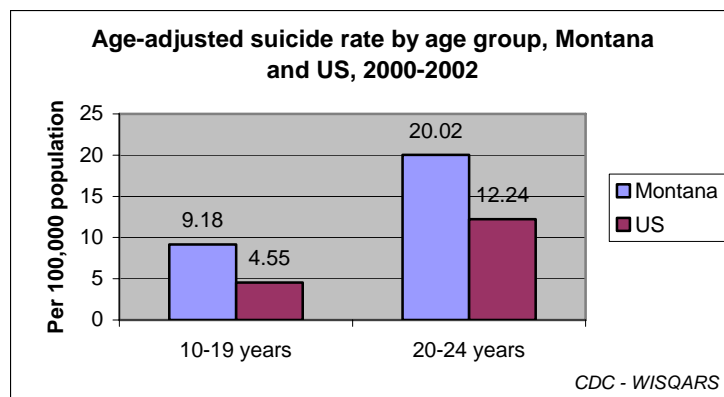
In 2002, Montana had an overall motor vehicle crashes death rate of 29.69 per 100,000 population compared to 14.85 nationally. There were a total of 270 deaths from motor vehicle crashes in 2002 in Montana. In 2000, the economic cost of motor vehicle crashes in Montana was 0.621 billion dollars (National Highway Traffic Safety Administration). In 2002, there were three deaths from motor vehicle crashes under the age of five. All of these children were unrestrained in the vehicle at the time of the crash. The Healthy People 2010 objective is to reduce the number of deaths caused by motor vehicle crashes to 9.2 per 100,000 population. The Healthy People 2010 objective for seat belts is to increase usage to 92%.

The 2003 YRBS reported that 17.8% of Montana teens rarely or never wore seat belts while riding in cars compared to 18.2% nationally. The YRBS also reported that 36.9% of teenagers rode with a driver who had been drinking within the past month compared to 30.2% nationally and 20.4% of Montana teens reported that they had driven a vehicle after drinking alcohol within the past thirty days compared to 12.1% nationally.

Suicide

Over the past decade, suicide has consistently ranked as the second leading cause of death in Montana among youth ages 10-24. Although the rate of youth suicide in Montana has decreased over the past decade, suicide rates in Montana remain higher than the national average. During 1995-1998, the suicide rate in Montana among ages 10-24 was 17.04 per 100,000. The US rate during that time period was 8.22 per 100,000.

During 2000-2002, the suicide rate among ages 10-24 in Montana was 12.58 per 100,000, compared to a US rate of 6.96 per 100,000. Similar to national statistics, the majority of youth in Montana who completed suicides between 2000-2002 were male.



Firearms are the most common cause of death among suicides in Montana.²² 2004 Behavioral Risk Factor Surveillance System (BRFSS) results report that 62.6% of adults in Montana have guns in or around their homes.

Data from the 2003 Youth Risk Behavior Survey (YRBS) indicate that Montana high school students are very similar to teens throughout the US in terms of thoughts of suicide and suicide attempts. Female high school students are more likely to feel sad or hopeless frequently enough to affect their daily activities, seriously consider attempting suicide and to actually attempt suicide.²³

Feeling Sad and Suicidal Behaviors, by Sex Montana and US, 2003 YRBS

	MT % Male	MT % Female	MT % Total	US % Total
Felt sad or hopeless	20.2 (±2.7)	33.1 (±2.7)	26.4 (±2.2)	28.6 (±1.7)
Seriously considered attempting suicide	13.8 (±2.3)	24.2 (±2.6)	18.9 (±1.9)	16.9 (±0.7)

²² WISQARS. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. <http://www.cdc.gov/ncipc/wisqars/> Accessed 6/22/05.

²³ Youth Risk Behavior Survey. National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. <http://apps.nccd.cdc.gov/yrbss/> Accessed 6/22/05.

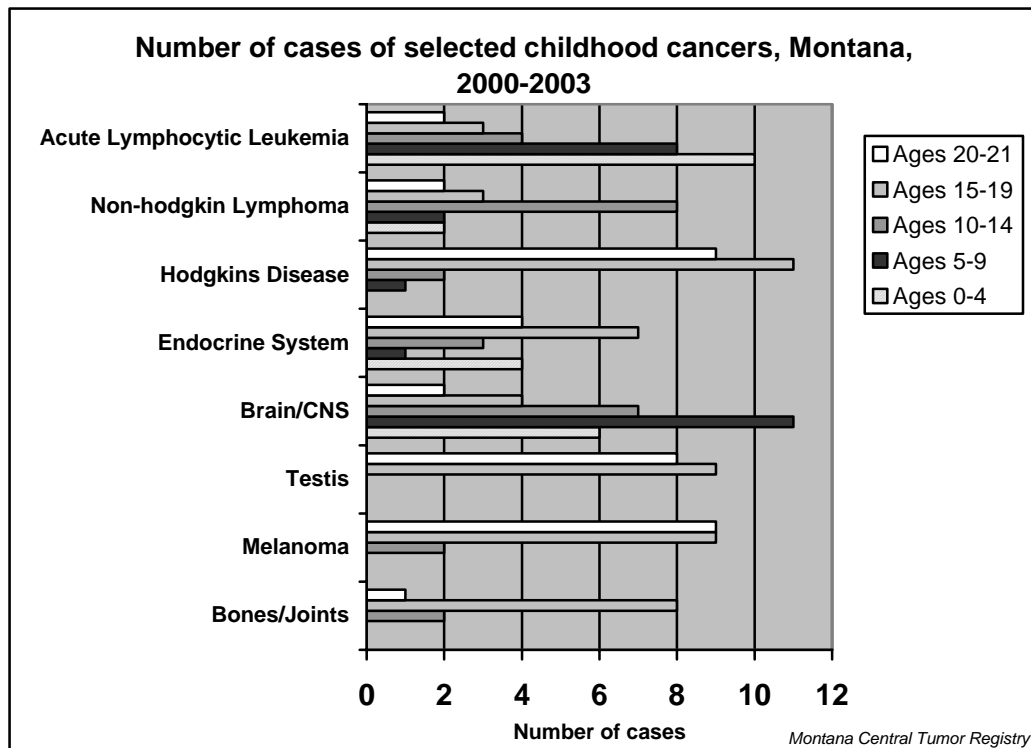
Made a suicide plan	11.7 (±2.0)	18.0 (±2.3)	14.8 (±1.6)	16.5 (±3.5)
Attempted suicide	6.8 (±1.7)	12.3 (±2.3)	9.7 (±1.3)	8.5 (±1.1)
Attempted suicide, required medical attention	2.3 (±0.9)	3.8 (±1.3)	3.0 (±0.8)	2.9 (±0.7)

The Healthy People 2010 goal is to reduce overall suicide to 5.0 suicides per 100,000 and to reduce adolescent suicide attempts to a twelve-month average of 1.0 percent. While Montana's suicide rate appears to be declining, the state has significant strides to make in addressing the causes and prevention of youth suicide to meet the HP2010 objective.

The availability and accessibility of mental health providers and social and economic factors can affect suicide rates. The low representation of mental health providers, particularly in rural areas, and comparatively high rate of poverty in Montana complicate prevention efforts and underscore the need for prevention and intervention efforts that consider the specifics of the environment in which youth live and the resources they have access to.

Childhood Cancer

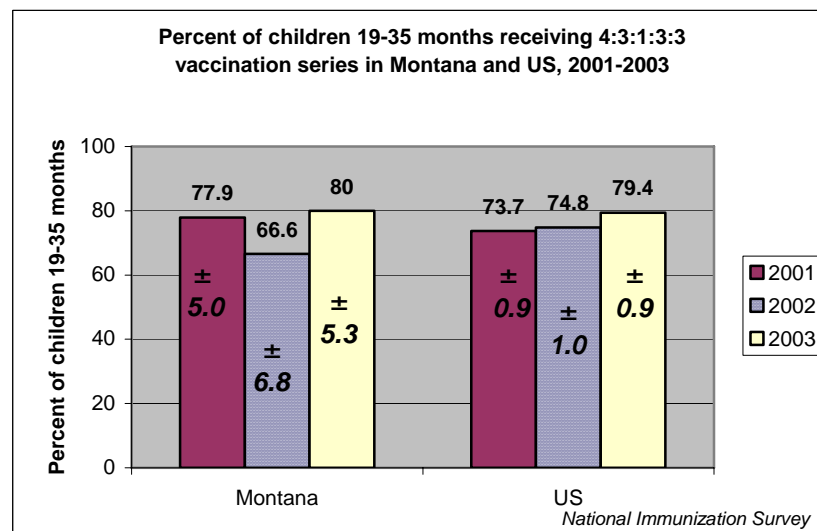
From 2000 through 2003, there were 225 cancers diagnosed in children ages 21 and under in Montana. From 1999 through 2002, there were a total of 27 deaths from cancers in children ages 0 through 19 in Montana. From 1998 through 2002, there were 3 cancer deaths among children ages 0-4, 9 deaths among children ages 5-9, 3 deaths among children ages 10-14, and 12 deaths among children ages 15-19. The three most common cancers found in children in Montana during this time were, cancers of the brain/central nervous system (30), acute lymphocytic leukemia (27), and Hodgkins Disease (23). During the previous 4-year period (1996-1999), the same types of cancer were the most common among children.



Immunization and Vaccine-Preventable Diseases

The National Immunization Survey (NIS) samples a very small proportion of children in Montana, and as a result the confidence intervals can be quite large and the vaccination rates can appear to vary quite a bit from year to year. However, as a general comparison tool, the NIS data shows that the state immunization rates are similar to national rates and close to the Healthy People 2010 objective (80 percent of children aged 19 to 35 months receive the recommended 4:3:1:3:3 vaccination series).

The Healthy People 2010 objective is to completely eliminate congenital rubella syndrome, diphtheria, Haemophilus influenzae type B, measles, mumps, polio, rubella and tetanus, and reduce Hepatitis B to 9 cases, pertussis to 2,000 cases and varicella to 400,000 cases nationwide within specific age groups.



Between 2000 and 2004 in all age groups in Montana there were no cases of congenital rubella, measles, mumps and polio, one reported case of laryngeal diphtheria, one case of tetanus, and 2 cases of Haemophilis influenza B. There were 8 cases of Hepatitis B in 2000, 3 in 2001, 10 in 2002, 16 in 2003 and 14 in 2004. In 2000, there were 35 cases of pertussis in Montana, 54 cases in 2001, 10 cases in 2002, 5 cases in 2003, and 84 in 2004. Montana experienced a pertussis outbreak in several counties in 2005 and had documented 380 cases in the state as of early June.

According to the NIS results, the only state vaccination rate that is statistically lower than the national rate is for varicella. Montana's Immunization Program is developing a statewide registry to track the vaccinations for all children, which will provide more accurate data on vaccination rates in the state.

Physical Activity and Obesity

According to the 2003 Youth Risk Behavior Survey (YRBS), youth in Montana are as active or more active than their peers nationally. In 2003, 25.3% of Montana students who watched three or more hours of TV per day on a school day, compared to 38.2% of children throughout the United States. Eighty-five percent of students enrolled in a physical education class in Montana exercised more than 20 minutes on average, versus 80% nationally.

However, a comparison of 2003 YRBS results with previous years indicate that Montana youth have become less active since 1999. In 2003, 62.3% of youth exercised or participated in vigorous physical activities for at least 20 minutes on three or more days during the previous week, as opposed to 69.5% in 1999.

The comparable Healthy People 2010 objective for exercise is to increase the proportion of adolescents who engage in vigorous activity 3 or more days per week to at least 85%. The HP 2010 objective for television viewing is to increase the proportion of adolescents who view 2 or fewer hours of television on a school day to 75%.

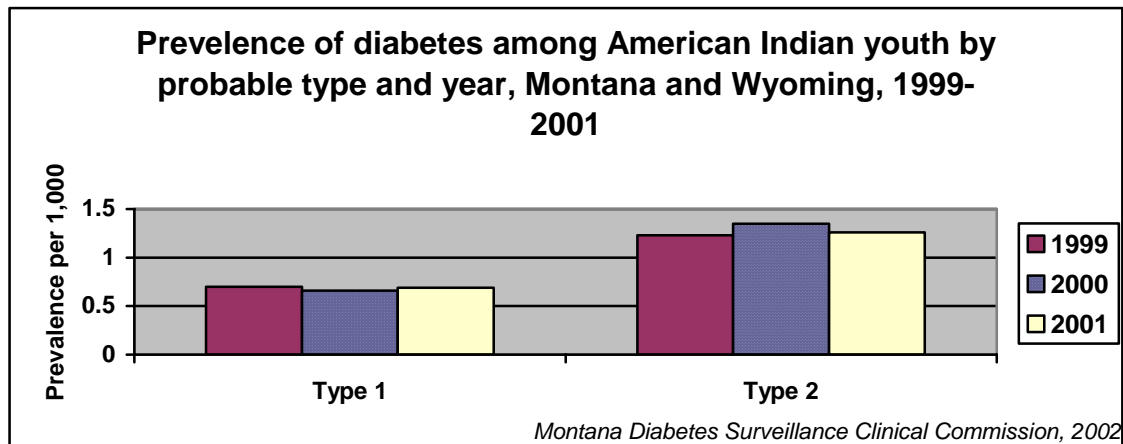
In 2003, 8.1% of Montana students were overweight (an increase from 6% in 1999), with 11.6% of students at risk for becoming overweight. 2003 YRBS results suggest that Montana youth have a lower rate of obesity and risk of becoming obese than youth in the United States as a whole. The Healthy People 2010 objective is to reduce the proportion of children and adolescents who are overweight or obese to 5%.

Weight and Dietary Behavior Among Youth Montana and US, 2003 YRBS		
	MT	US
	%	%
At-risk of becoming overweight	11.6 (±1.3)	14.8 (±0.7)
Overweight	8.1 (±1.5)	12.1 (±1.3)
Ate less food, fewer calories or foods low in fat to lose weight or keep from gaining weight	39.5 (±1.8)	42.2 (±1.5)
Went without eating for 24 hours or more to lose weight or keep from gaining weight	11.6 (±1.2)	13.3 (±1.1)

Took diet pills, powders or liquids to lose weight or keep from gaining weight	6.7 (± 0.9)	9.2 (± 1.5)
Ate 5 or more servings of fruits & vegetables per day during past week	16.7 (± 1.7)	22.0 (± 1.4)
Drank 3 or more glasses of milk per day during past week	22.5 (± 1.8)	17.1 (± 2.7)

Diabetes

Diabetes has been a growing concern due to the increased number of cases that have been diagnosed. Native Americans have a higher rate of diabetes than the white population in Montana.



Asthma

In 2003, there were 14 deaths due to asthma in Montana; all of the individuals were over 30 years old, and 70% were over 60.²⁴ According to the 2002 Montana Behavioral Risk Factor Surveillance System (BRFSS), 14.5% of adults reported that a doctor, nurse or other health professional had told them they had asthma. When asked if they still had asthma, 62.7% responded yes. According to the 2004 BRFSS, 7.9% of Montana residents are at risk for asthma, which is the same as the median nationwide rate of 7.9%.²⁵

During June 1, 2000 to May 31, 2002, an asthma study was conducted using data from three community health centers in Montana. This survey was conducted to fill the gap of underreporting that is believed to occur with childhood asthma. The average prevalence among children ages 2-17 was 5.0%.²⁶

A question regarding asthma in children was added to the 2004 BRFSS. Although the data are not currently available, when they are analyzed they will provide additional information on asthma in Montana children.

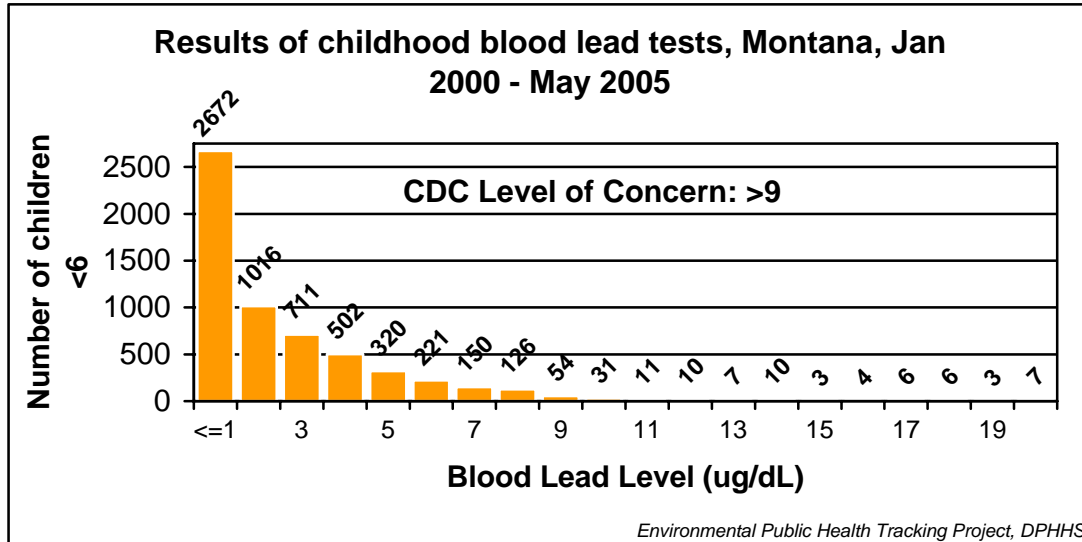
²⁴ Montana Vital Statistics, 2003. Office of Vital Statistics, Montana Department of Public Health and Human Services. December 2004.

²⁵ Behavioral Risk Factor Surveillance System (BRFSS). National Center for Chronic Disease Prevention and Health Promotion. Centers for Disease Control and Prevention. 2002.

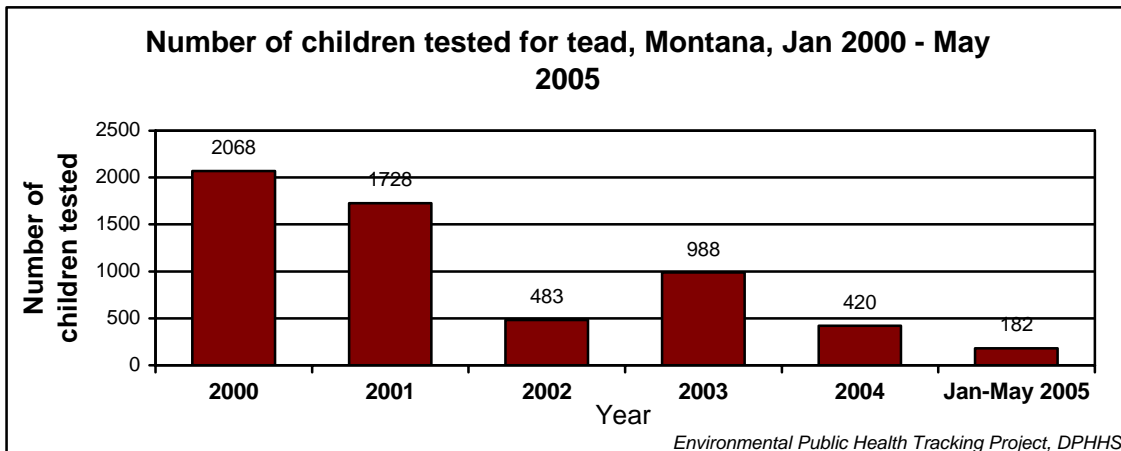
²⁶ Asthma Report, Montana Department of Public Health and Human Services. 2002.

Lead Poisoning

The CDC has determined a recommended level of lead to be no more than 10 micrograms of lead per deciliter of blood. Of the 5869 children tested in Montana between 2000 and May of 2005, 98 had blood levels of ten micrograms or greater. The Healthy People 2010 objective is to eliminate elevated blood levels in children.



A statewide Lead Program was discontinued in 2001 due to a lack of funding. As a result, the number of children tested for lead has fallen, which limits the comparability of current data to that of previous time periods. Lead monitoring and abatement efforts continue in some local jurisdictions, particularly those with previously identified high lead levels due to smelting activities. The results of blood lead level lab tests continue to be reported to the Department of Public Health and Human Services.



Oral Health

Poor oral health can have detrimental effects on overall health and well-being. Preventing and identifying oral health diseases and conditions in children can avert future disease and more serious health effects. The Healthy People 2010 objective regarding

dental caries is to reduce the proportion of young children with dental caries experience in their primary teeth to 11% and reduce the proportion of children with dental caries experience in their primary and permanent teeth to 42%. The Healthy People 2010 objective for sealants is to increase the percent of children aged 8 and adolescents age 14 who receive sealants on their molars to 50%.

A 2003/2004 statewide screening of 20060 Montana students ages 5 to 14 years found that approximately 62% of students had not had sealants applied and over 26% had untreated dental decay at the time of the screening. In 2002, only 67% of Montana children enrolled in Head Start received a dental examination and 29% of those examined were diagnosed as needing dental treatment. Among women of childbearing age, an analysis of 2002 Montana Pregnancy Risk Assessment Monitoring System (PRAMS) results showed a significant association between respondents who had a dental problem during pregnancy and low birth weight outcomes.

Montana faces critical access problems in oral health care due to a number of factors including inadequate supply and mal-distribution of dental professionals, high poverty levels and numbers of uninsured, and limited access to dental services for low income and special populations. According to the Montana Primary Care Office, 37 of Montana's 56 counties are designated as Dental Health Professional Shortage Areas (Appendix F); 12 of those counties have no dentists at all and 15 have no dental hygienists. Twenty-three percent of counties did not have an enrolled Medicaid dentist in 2003, and those dentists who do accept Medicaid may have limits on the numbers of patients they will accept and types of services provided. Only 10 pediatric dentists are currently practicing in the state. Indian Health Service (IHS) estimates that only about 20% of oral health needs of Native American population are being met because of limited funding and difficulty in recruiting and retaining providers.²⁷

Seventy-four percent of Montanans do not have access to optimally fluoridated water. Fluoridation levels in Montana's water systems and wells vary greatly by location and only 6 communities (all but one with populations under 10,000) have adopted water fluoridation. MCH dollars support a weekly school-based fluoride mouth rinse program that serves nearly 40,000 children to prevent tooth decay in communities that do not have optimal levels of fluoride in their public water supply.

Montana has a lower dentist/population ratio than the US as a whole and is facing a "graying" of the dental health workforce, with approximately 30% of practicing dentists over the age of 50.

Montana's Community Health Center (CHC) dental clinics are an important resource for low-income families, however, recruiting and retaining dental staff is difficult, especially in rural areas, and only 7 of the 11 CHCs currently provide dental services, while two are currently recruiting for a provider. Even those with dental providers may have difficulty

²⁷ The State of Oral Health in Montana. Montana Department of Public Health and Human Services. June, 2004.

keeping up with demand; one clinic has over 2000 people on the waiting list for dental services.

Another of Montana's challenges is the lack of dental educational opportunities. Montana does not have a dental school and only one WICHE (Western Interstate Commission for Higher Education) dental student and 2 University of Minnesota dental students per year receive state support for dental education. Some efforts have been made to address the need for qualified dentists in Montana. In 2001 and 2003, the state legislature provided financial support for a school of dental hygiene, which Montana had been lacking for over a decade. During the 2005 legislative session, licensure barriers precluding dental student rotation programs were removed and funding was approved to conduct a feasibility study on establishing a reciprocal school of dentistry with the University of Washington.

Mental Health

Fifty of Montana's 56 counties are considered Mental Health Professional Shortage Areas. Even in those areas that are not designated as shortage areas, waiting lists to access providers may be lengthy and those without insurance coverage may have difficulty getting the services they need. Montana has one state-run hospital located in Warm Springs. There are 4 regional mental health centers: Golden Triangle Community Mental Health Center, Eastern Montana Community Mental Health Center, South Central Regional Mental Health Center and Western Montana Community Mental Health Center. According to the state licensing bureau, there are 101 licensed psychiatrists in the state, 405 licensed clinical social workers and 768 licensed clinical professional counselors. 5 sites are authorized to provide acute inpatient services to youth on Medicaid. In 2003 they served 19 Medicaid clients under age 20 and 5 aged 18 to 20. 37 providers provided Medicaid-covered outpatient therapeutic services to 70 youth in 2003.

The children's Medicaid mental health plan served 9,151 youth in state fiscal year 2002, 9,422 youth in 2003, and 9,208 youth in 2004. Of the youth served in 2004, 80.1% were Caucasian, 15.4% were Native American, 1.3% were African American, 2.9% were Hispanic, and .2% were Asian or Pacific Islander.

The least restrictive level of care available in Montana is community-based outpatient therapeutic services. Among the services included in community-based outpatient services are: school-based day treatment, and comprehensive school and community treatment (CSCT); individual, family and group therapy; case management; and mental health center services. The most restrictive level of care available is inpatient psychiatric residential treatment (RTC). This level of intense treatment is often used after the lesser restrictive levels of treatment are determined not appropriate for the treatment needs of the youth. Montana has three privately operated residential treatment centers for youth under the age of 18. Residential treatment centers provide 24 hour supervised care. RTC treatment is considered appropriate when the youth's behavior is so dangerous to self or other, or destructive that the youth requires 24 hour-treatment under the direction of a physician.

Reproductive Health

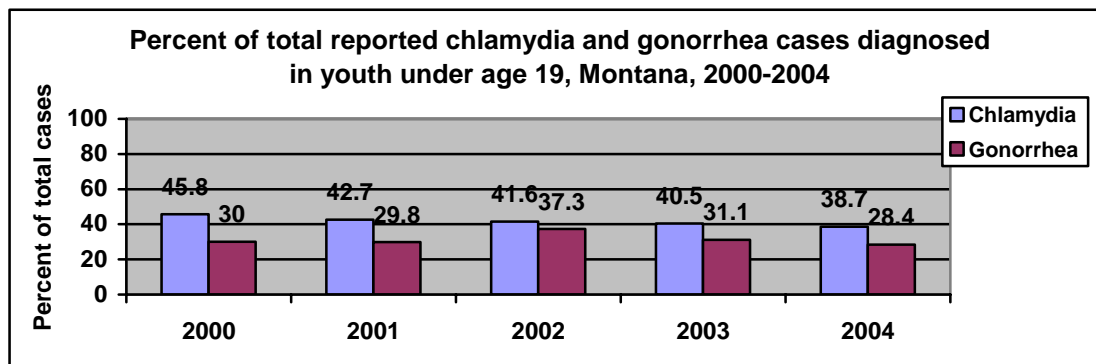
Results from the 2003 YRBS indicated that 43.6% of high school males and females had ever had sexual intercourse, 5.9% of high school students had sexual intercourse before the age of thirteen, and 14% of students have had four or more sexual partners during their life. Healthy People 2010 objectives are to increase the number of adolescents who have never engaged in sexual intercourse before age 15 years to 88% and to increase the number of adolescents who have never engaged in sexual intercourse to 75%.

There were 29.9% of respondents who reported having sexual intercourse with one or more people in the last month. Thirty-four percent of high school students reported using drugs or alcohol before engaging in sexual intercourse. Of students who are sexually active, 59.6% reported using a condom during last sexual intercourse and 24.1% reported using birth control pills during last sexual intercourse.

Youth Sexual Activity Montana and US, 2003 YRBS		
	MT	US
	%	%
Ever had sexual intercourse	43.6 (±3.3)	46.7 (±2.6)
First sexual intercourse before 13	5.9 (±1.3)	7.4 (±1.2)
Sexually active during past 3 months	29.9 (±2.8)	34.3 (±2.1)
Condom use during last sexual intercourse	59.6 (±4.0)	63.0 (±2.5)
Four or more sexual partners during lifetime	14.0 (±2.3)	14.4 (±1.6)
Alcohol or drug use during last sexual intercourse	33.7 (±4.7)	25.4 (±2.3)
Birth control pills during last sexual intercourse	24.1 (±3.4)	17.0 (±2.3)
Been pregnant or have gotten someone pregnant	3.9 (±1.1)	4.2 (±0.8)
HIV/AIDS infection education in school	88.1 (±2.3)	87.9 (±1.9)

Sexually Transmitted Diseases

Over 28% of total gonorrhea cases in Montana in 2004 were diagnosed in youth under age 19. Of the total number of chlamydia cases reported in Montana in 2004, 38.7 were in youth under 19. The proportion of total chlamydia cases that are diagnosed in youth has gradually been declining since 2000.



HIV/AIDS

Between 1985 and the end of 2004, 15 cases of HIV/AIDS in children or youth age 19 and younger were reported to DPHHS. This represents 2.4 % of the total number of HIV/AIDS cases reported in Montana during this time period.

Tobacco Use

The percentage of teens smoking in Montana in 2003 is similar to the national percentage. Almost 23% of Montana teens reported smoking cigarettes during the last month on the YRBS, compared to 21.9% of all US teens. However, a higher percentage of Montana youth who were current smokers reported trying to quit during the past 12 months. Sixty-one percent of Montana youth reported ever trying cigarettes.

Montana has a high rate of smokeless tobacco use among youth; 13% of Montana teens reported using smokeless tobacco during the past month, while only 6.7% of teens throughout the U.S did.

Use of Tobacco Products by Youth Montana and US, 2003 YRBS		
	Montana %	US %
Ever tried cigarette smoking	61 (±3.8)	58.4 (±3.1)
Smoked a whole cigarette before age 13	20.7 (±2.7)	18.3 (±1.7)
Smoked cigarettes at least one day in past 30	22.9 (±3.0)	21.9 (±1.4)
Smoked cigarettes 20 out of last 30 days	10.8 (±1.9)	9.7 (±1.4)
Current smokers, tried to quit in past 12 months	60.9 (±4.7)	53.8 (±2.9)
Used chewing tobacco or snuff	13.2 (±2.2)	6.7 (±1.5)
Used any tobacco in the past 30 days	30.9 (±2.9)	27.5 (±2.4)

Cigarette smoking and use of smokeless tobacco among adolescents in Montana has decreased significantly since 1997. In 1997, 19.3% of youth smoked on at least 20 days during the previous month and 21% used smokeless tobacco. The Healthy People 2010 objective for tobacco use is to reduce usage by students in grades 9-12 to 21%.

Alcohol Use

In 2003, 49.5% of Montana teens reported drinking alcohol in the past month compared to 44.9% nationally. Eight-one percent of Montana teens reported having ever had alcohol compared to 75% nationally. 2003 YRBS results indicate that Montana teens are more likely to ride in vehicles where someone else has been drinking and drive a car after they had been drinking themselves.

Alcohol Use by Youth Montana and US, 2003 YRBS		
	MT %	US %
At least one drink on one or more days of their life	81.1 (±2.1)	74.9 (±2.7)
Had first drink other than a few sips before age 13	30.4 (±3.1)	27.8 (±2.1)

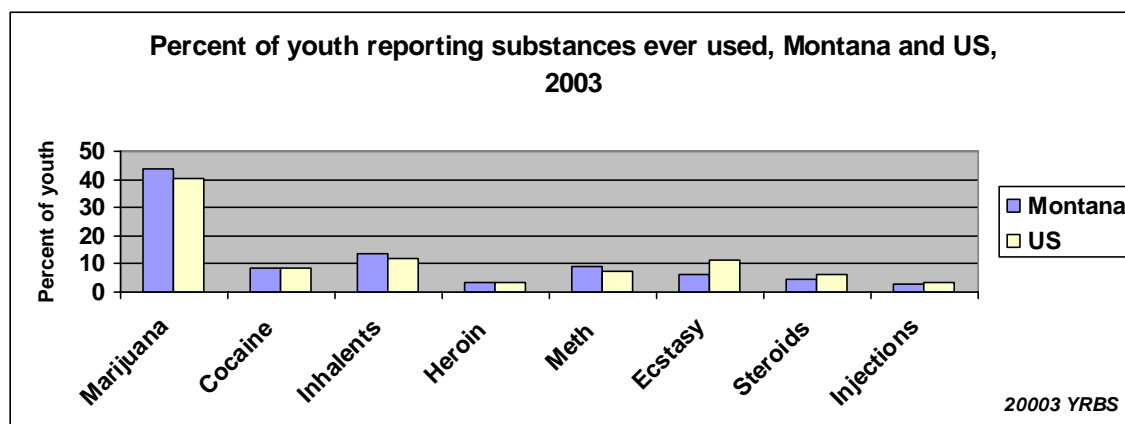
Had at least one drink in past 30 days	49.5 (± 3.3)	44.9 (± 2.4)
Had five or more drinks in a row on 1 or more days in past 30 days	37.3 (± 3.1)	28.3 (± 2.0)
Rode one or more times in a car or vehicle driven by someone who had been drinking, past 30 days	36.9 (± 2.9)	30.2 (± 2.1)
Drove a car or vehicle one or more times after drinking, past 30 days	20.4 (± 2.6)	12.1 (± 1.2)

The Healthy People 2010 objective is to increase the average age of first use of alcohol in adolescents to 16.1 years and to reduce the number of high school seniors engaging in binge drinking to 11%. In 2003, 37.3% of Montana adolescents had had five or more drinks of alcohol in a row within a couple of hours within the last 30 days.

Illicit Drug Use

The use of drugs among Montana adolescents is similar to that among all US teens. According to 2003 YRBS results, the use of ecstasy is the only drug for which the percentage of Montana teens who ever used it is statistically different than the percentage of US teens who ever used it. Fewer Montana teens than US teens have used ecstasy. However, although the percentages of Montana youth using drugs are similar to those at the national level, use of illegal drugs continues to be a significant risk factor among Montana youth. The Healthy People 2010 objective is to increase the average age of first use of drugs in adolescents aged 12 to 17 years to 17.4 years and to increase in high school seniors never using illicit drugs to 56%.

Illicit Drug Use by Youth Montana and US, 2003 YRBS		
	MT %	US %
Tried marijuana before age 13	11 (± 2.4)	9.9 (± 1.3)
Used marijuana in past 30 days	23.1 (± 2.8)	22.4 (± 2.1)
Used cocaine in past 30 days	3.8 (± 1.0)	4.1 (± 0.9)
Used inhalants in past 30 days	4.2 (± 1.0)	3.9 (± 0.6)
Used methamphetamines one or more times during life	9.3 (± 1.5)	7.6 (± 0.9)
Used ecstasy	6.1 (± 1.2)	11.1 (± 3.7)
Offered, sold or given illegal drugs on school property, past 12 mo.	26.9 (± 2.4)	28.7 (± 3.8)



VI. CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

STAKEHOLDER SURVEY RESULTS

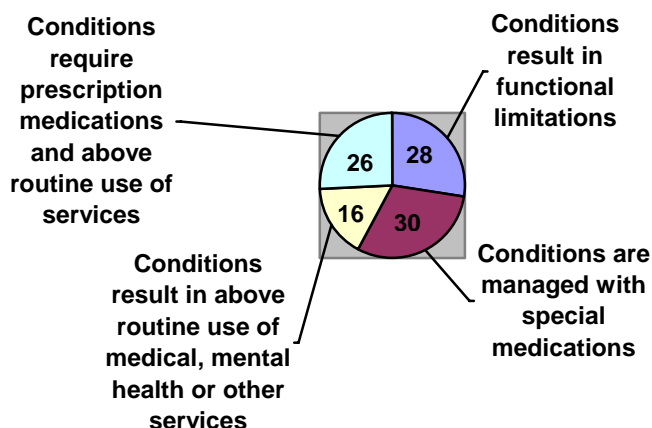
Needs that consistently emerged as top priorities for this MCH population included:

CYSHCN

- Access to dental care
- Access to health care
- Clinics to address the special needs of children
- Mental health services
- Respite care for parents and caregivers
- Health insurance

Montana uses a broad definition of children and youth with special health care needs (CYSHCN) to include children at high risk. Inclusion of “at risk” children has allowed services to be more inclusive. According to the National Survey of Children with Special Health Care Needs, the prevalence of CYSHCN in Montana is approximately 11.8%, slightly lower than the national average of 12.8%. The majority of CYSHCN in Montana are ages 8-14, and males make up just over 50% of the CYSHCN population.

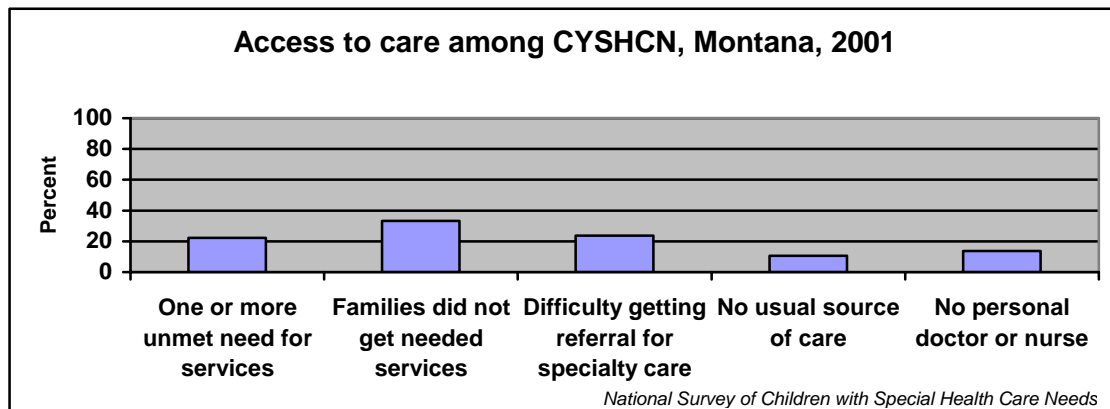
Specific Health Care Needs of CYSHCN in Montana, 2001



National Survey of Children with Special Health Care Needs, 2001

Accessing specialized services is of particular concern in a state the size of Montana, with scattered population centers. While seeing even a primary care physician is a challenge for children in some areas of the state, for children with special health care

needs the specialist care they require may be even farther away, or only offered sporadically. National Survey data indicate that access to care affects a higher percentage of CYSHCN in Montana than nationally.



Financial considerations are another barrier to care. Approximately 14.6% of CYSHCN in Montana live in households with incomes less than 100% of the federal poverty level (FPL) and 26.6% of families experienced financial problems due to their child's health needs. Approximately 12% of CYSHCN are uninsured, over twice the national number, and 38.9% of those who are insured have inadequate coverage.²⁸

Prevalence of Special Health Care Needs in Montana 2005	
Condition	% of clients by occurrence
Complications of prematurity and newborn perinatal conditions	15%
Neurological conditions including seizure disorders, ARND, NTD, CP	13%
Conditions with multiple congenital anomalies and syndromal conditions	13%
Childhood disorders including LD, Speech and Language delay, ADD/ADHD	13%
Endocrine, Immune, and Metabolic conditions	12%
Cardiovascular conditions	10%
GI/Cleft/craniofacial conditions	08%
Respiratory conditions including asthma	07%
Other physiological conditions	06%
Other psychological (mental) conditions*	03%

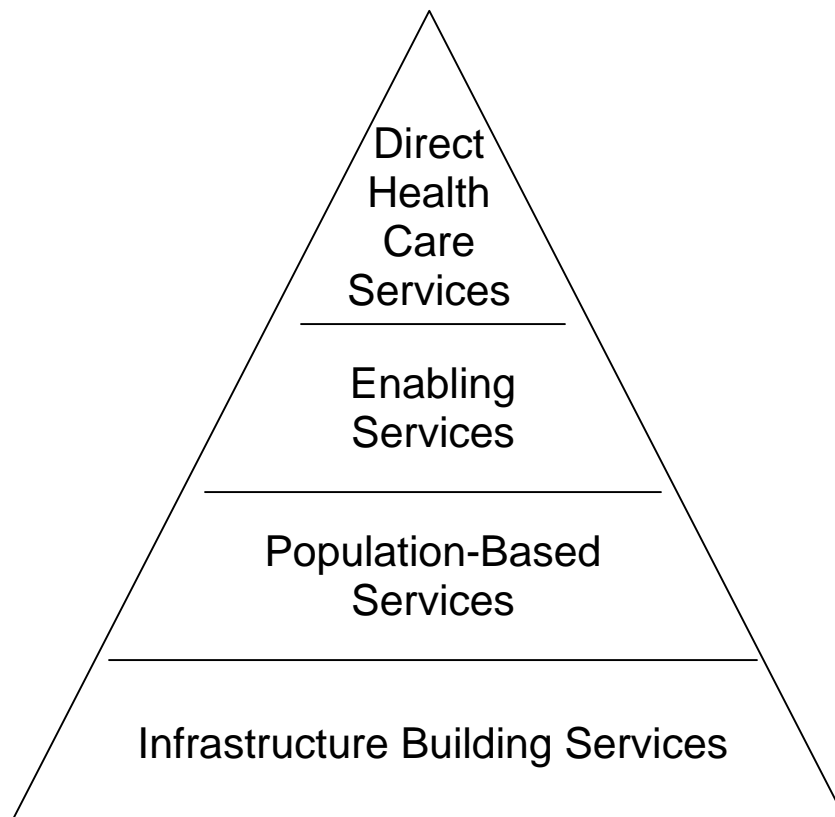
Montana Children's Special Health Services *Note: Childhood disorders including ADHD are separated from mental disorders.

²⁸ National Survey of Children with Special Health Care Needs, 2001.

<http://cshcndata.org/DesktopDefault.aspx?topic=stateprevalence&geo=Montana> Accessed 6/27/05.

VII. MATERNAL AND CHILD HEALTH PROGRAMS AND ACTIVITIES

The sections below describe the maternal and child health programs and activities in Montana. The programs are first listed in tables according to the level of the Title V pyramid they fall into. The MCH population covered by each program is noted. The last column on the table lists the index number that corresponds with a more detailed program description in the section following the tables.



Direct Health Care Services:

Program	Target Group	Eligibility	Program Description	Provider	Index Number
Chemical Dependency Program	Chemically dependent youth	Addicted children	Provides counseling and other services to prevent addictions	Mental health providers	4
Children's Special Health Services and Specialty Clinics	CSHCN	Medical	Clinic providing care, education, and referral to other services for children with various special health problems	Multiple: MD, specialist, case manager	7
Dental Care (Medicaid)	Children 1-21	Medicaid Recipient	Program that provides dental care check-ups for children on Medicaid	Dentists	11
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Children birth through age 20	Medicaid enrollees	Provide preventative well-child check ups and any treatment that is medically necessary even if not specifically stated in the Medicaid state plan	Medicaid providers	14

Family Planning Services	Women 13-44	None	Program that provides health screenings and family planning resources to educate clients and prevent unintentional pregnancies and STDs, including HIV.	Advanced Practice Registered Nurses, Physician Assistants, MD's and Registered Nurses.	19
Genetics Program	Parents and prospective parents, infants	None	Provide testing, counseling and referral for management of genetic disorders.	Shodair Children's Hospital, DPHHS	25
Indian Health Services	MCH population	Native American heritage	Provides direct health care services	IHS	29
Mental Health Program	Children with mental disorders		Provides mental health care through community providers	Mental health providers	31
Prenatal care	Pregnant women	None	Any direct service or procedure provided to a pregnant woman	Public Health Nurses	46
Ryan White Care Act Programs	HIV+ Women	HIV+ Status	Provides financial assistance for medications	Medical providers	52

Enabling Services:

Program	Target Group	Eligibility	Program Description	Provider	Index Number
Caring Program for Children	Uninsured children ages 0-18	Children w/o access to private insurance, Medicaid, or CHIP	Provides basic medical, dental, and vision coverage for children with financial barriers	Blue Cross/ Blue Shield enables access to professional medical care	3
Child and Adult Care Food Program (CACFP)	Children in child care	All children who are in child care outside of a residential setting	Provides nutritious meals and nutrition education		5
Children's Health Insurance Program (CHIP)	Children 1-18	Below 150% of poverty and Medicaid ineligible	Provides basic medical, dental and vision coverage for children ineligible for Medicaid	Multiple health professionals	6

Children's Special Health Services and Regional Special Health Clinics	CYSHCN	200% of FPL & medical condition	Limited assistance with cost of services related to special healthcare needs	Multiple health professionals	7
Developmentally Disabled Waiver Program/ Medicaid	CYSHCN	1-18 years of age, with a special health care need	State waives certain federal requirements to provide health services to CYSHCN	Multiple health professionals	12
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Children birth through age 20	Medicaid enrollees	Provide preventative well-child check ups and any treatment that is medically necessary even if not specifically stated in the Medicaid state plan	Medicaid providers	14
Family Planning Services	Women 13-44	None	Program that provides health screenings and family planning resources to educate clients and prevent unintentional pregnancies and STDs, including HIV.	Advanced Practice Registered Nurses, Physician Assistants, MD's and Registered Nurses.	19
Fetal Alcohol Prevention Program (FAPP)	Pregnant at risk of having a child with fetal alcohol syndrome or fetal alcohol effect	None	Create 4-state FAS consortium, assess impact of FAS on region, home visiting and case management	Public Health Home Visiting Intervention Teams	20

Fetal Alcohol Spectrum Disorders Program	High risk pregnant women and infants and children exposed to alcohol in utero	None	To identify high-risk populations, test-interventions and collect data that will assist in understanding the problem of FADS and provide information to the general public and target professionals	Public Health Home Visiting Intervention Teams	21
Follow-up of Abnormal Newborn Screenings; including hearing	CSHCN	None	Follow-up program of abnormal newborn screens, facilitates links to other needed special services	Multiple health professionals	24
Head Start/Early Head Start	Children birth to 5 years and pregnant women	Low income	Early childhood education and referrals, parent education	Head Start staff	26
Healthy Mothers Healthy Babies	Uninsured children ages 0-18	Children w/o insurance	Connects uninsured children and families with low-cost medical insurance	CHIP, Medicaid and other low-cost insurance programs	27
Medicaid	MCH Population	Low-income	Provides medical insurance for low-income families and individuals	Medicaid; Blue Cross/ Blue Shield	30
Mentoring to Quit – M2Q	Pregnant women and mothers	Smoker	Mentoring program for women who smoke with women who have successful quit smoker	Healthy Mothers, Healthy Babies (HMHB)	32
Part C/Early Intervention	CSHCN		Provides case management for children with special health care needs until the age of three	Various special health care need providers	44
Public Health Home Visiting	Pregnant women & infants	High risk pregnant women & infants	Program that addresses the barriers to the reduction of infant mortality (prenatal care, medical care, etc.)	Public Health Nurses, social workers, dietitians	48
Rape Prevention Education	MCH population	None	Provides education on rape	Local community organizations	50
Children's Special Health Services and Regional Special Health Clinics	CYSHCN	Children diagnosed with or suspected of having a condition addressed at the clinic	Regionalize special health care clinics and enhance efficiency of care for CYSHCN	Children's Special Health Services	7
Relief From Asthma Project and Nurse First	Medicaid children with asthma	Medicaid eligible children	Case management for children with asthma.	Local providers, Medicaid	51

Sexual Assault Program	Sexually assaulted individuals	None	Provides services, support and education about sexual assault	Local community organizations	58
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	Pregnant women, breastfeeding women, post-partum women, infants, & children under 5 yrs.	Medical/nutritional risk, financial, residential and categorical criteria	Nutritional education, breastfeeding education, referrals to health care providers and social services, food supplements, federally funded	WIC Staff	60
Suicide Prevention Hotline		None	Provide crisis intervention and referrals	Hotline staff	62
Targeted Case Management - Medicaid	CSHCN	Medicaid eligible	Provides targeted case management	Multiple health professionals	65
WIC - Farmer's Market Program	Pregnant women, breastfeeding women, post-partum women, & children under 5 yrs.	Current participants in WIC Medical/nutritional risk, financial, residential and categorical criteria	Nutrition education and financial assistance to purchase fresh fruits and vegetables at farmer's markets from local farmers	WIC staff	67

Population-Based Services:

Program	Target Group	Eligibility	Program Description	Provider	Index Number
Adult Immunization Program	Women and men	None	Program to provide immunization and education on disease prevention to adults	Public health clinics	1
CJ Foundation for SIDS Grant	Women and infants	None	Provides educational campaigns about SIDS	Public health nurses and FCHB	8
Family Planning Services	Women 13-44	None	Program that provides health screenings and family planning resources to educate clients and prevent unintentional pregnancies and STDs, including HIV.	Advanced Practice Registered Nurses, Physician Assistants, MD's and Registered Nurses	19
Montana Safe Kids Safe Communities	Mothers, infants and children	None	Provides awareness campaign on traffic safety	HMHB staff	37

Montana' Safe Kids Campaign	Mothers, infants and children	None	Provides education on water safety and other childhood safety issues	HMHB staff	38
Montana's Child	Mothers, infants and children	None	Provides education on pregnancy, child health and maternal health. Provides resources and link-up to other services. 1-800 number for MCH questions	HMHB staff	39
Newborn Hearing Screening	Newborns	None	Screening for hearing deficiencies	Hospitals	41
Newborn Screening Monitoring Program	Newborns	None	Universal screening of all newborns for inborn errors of metabolism	Hospitals	42
Oral Health Screenings	Children 5-18 & 3 rd graders	None	Screens children in school to identify oral health needs, assist in referral efforts, and collect needs assessment data	Volunteer dental, health, and school professionals	43
Perinatal Substance Abuse Prevention	High risk pregnant women	None	To identify high-risk populations, test-interventions and collect data that will assist in understanding the problem of in utero exposure to drugs and alcohol and provide information to the general public and target professionals	Public Health Home Visiting Teams	45
Quality Diabetes Education Program	Mothers, infants and children	None	Provides general education and diabetes counselors	Diabetes counselors	49
Safe Sleep for Baby	At-risk families	None	Provides educational information about safe sleep environments for infants and reducing SIDS risk	FCHB, HMHB	53

Safe Sleep Rules for Daycares	Infants in daycare	None	Licensing rules for daycare require that infants be placed to sleep on their backs	State Licensing, daycare providers	54
School-Based Fluoride Mouth Rinse Program	Children 5-18	None	Weekly fluoride mouth rinse is provided to all children in serviced schools to help prevent tooth decay	Dental, public health, school, & parent volunteers	55
School-Based Health Screenings	School-aged children	Enrolled in school	Various screenings provided in some schools by school nurses or county public health nurses	Schools, districts and/or counties	56
SIDS: A Guide for Child Care Providers	Childcare providers, hospitals	None	Provides educational information about SIDS	FCHB	59
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	Pregnant women, breastfeeding women, post-partum women, infants, & children under 5 yrs.	Medical/nutritional risk, financial, residential and categorical criteria	Nutritional education, breastfeeding education, referrals to health care providers and social services, food supplements, federally funded	WIC staff	60
Statewide Immunization Efforts	Infants	None	County Health Departments provide immunizations	Public health clinics	64
Vaccines for Children	Infants and children 0-18 years	Medicaid eligible, Alaska Native, Native American, uninsured, or insured w/o vaccine coverage	Provides immunizations at no charge	Public health clinics	66

Infrastructure Building Services:

Program	Program Description	Provider	Index Number
Asthma education and legislation	Distribution of asthma educational materials to day care providers and other public health professionals	DPHHS	2
Community Incentive Program and Community Incentive Program - Enhancement	Develop a comprehensive and coordinated risk protective system focused on prevention and delivery systems of substance abuse. Build capacity and infrastructure within communities to prevent substance abuse	Federal state incentive grant	9

Diabetes Quality Improvement Program	Collects baseline diabetes data and monitors diabetic patients to develop and implement quality improvement interventions	Primary care practices	10
Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA)	Infrastructure building program to implement and/or enhance domestic violence prevention protocols at the local level	Coordinated Community Response Teams	13
Early Childhood Comprehensive System (ECCS)	Develops and Implements collaborations and partnerships to support families & communities to prepare healthy kids at school entry	Stakeholders in early childhood programs and services	15
Environmental Public Health Tracking (EPHT)	Provide information from a nation-wide network of integrated environmental monitoring and public health data systems in order to prevent and control environmental hazards to health	Various stakeholders	16
Family and Community Health Advisory Council	Advises the State Family and Community Health Bureau on matters impacting the health and well being of MCH populations	Appointed members who represent a range of stakeholders	17
Family and Community Health Bureau	Administers and coordinates MCH services throughout the state, including the Maternal and Child Health Block Grant	State staff	18
Fetal Alcohol Syndrome (FAS) Advisory Council	Assists state to implement programs and recommend public policy	FASD stakeholders and service providers	22
Fetal, Infant and Child Mortality Review	Program to review fetal, infant, and child deaths to provide recommendations to prevent future incidents	Local and state teams	23
Healthy Child Care Montana Project, SEE ECCS	Increase access to quality childcare providers	Contracted through a local health department	15
IDEA Project	Enhance integration and efficiency of the management of public health data across the state	State	28
Montana Birth Outcomes Monitoring System	Program that tracks targeted birth outcomes, provides surveillances of newborns with targeted outcomes and promotes coordination among providers of services to children with congenital birth defects.	Maternal and Child Health Data Monitoring section of DPHHS	33
Montana Coalition Against Domestic and Sexual Violence	Provides technical assistance, training, networking and training for members	Domestic violence partners	34

Montana Council for Maternal and Child Health	Promotes well being of children by identifying and educating Montanans about the services considered to be vital to children. Provides recommendations to the state legislature on children's issues	Stakeholders for maternal and child health	35
Montana Oral Health Alliance (Montana Dental Access Coalition)	Montana Oral Health Plan State-Based Oral Health Surveillance System	Oral health stakeholders	36
Montana Strategic Suicide Prevention Plan	Statewide plan for reducing suicide among Montana's youth	DPHHS, state partners	40
Part C/Early Intervention	Provides case management for children with special health care needs until the age of three	Various special health care needs providers	44
Public Health Home Visiting	Program that addresses the barriers to the reduction of infant mortality (prenatal care, medical care, etc.)	Public Health Nurses, social workers, dietitians	48
Protect My Air	Inspection of indoor environment of daycares during routine inspections	State Licensing	47
Children's Special Health Services and Regional Special Health Clinics	Regionalize special health care clinics and enhance efficiency of care for CYSHCN	Children's Special Health Services	7
Safe Sleep Rules for Daycares	Licensing rules for daycare require that infants be placed to sleep on their backs	State Licensing, daycare providers	54
Seven Sisters Native Coalition	Networking organization to build domestic violence services in the Indian reservations	Various Native American stakeholders in domestic violence	57
Strategic Prevention Framework State Incentive Grant	Developing an Epidemiological Workgroup to identify priority areas to implement evidence based substance abuse prevention programs	DPHHS, partners	61
Suicide Prevention Mini Grants	Communities, FICMR teams and Indian Development and Education Alliance (IDEA) partner to reduce teen suicide	Communities, IDEA, FIMCR teams	63

Program and Activity Descriptions:

Following each program description is a notation with the sections of the Title V pyramid the program falls under: Direct Health Care (DHC), Enabling Services (E), Population-based Services (PB), and Infrastructure Building Services (IB).

1. Adult Immunization Program

Some counties utilize MCH Block Grant funds to provide immunizations for adult clients and education on disease prevention. The Immunization Section of the DPHHS provides support for these programs in the county public health clinics and in the STD/HIV Counseling and Testing Sites. Women of childbearing age may access vaccines through most local public health clinics at no cost or a reduced rate. Public clinics provide immunizations at a sliding, reduced or waived fees depending on the client's ability to pay. (PB)

2. Asthma Education and Legislation

The Child Health Coordinator of the Family and Community Health Bureau developed and distributed a guide titled "Asthma and Childcare: What You Need to Know" to every registered daycare provider in MT through their registration renewal process. Outreach and education was provided to daycare providers at two state conferences, and to public health nurses at the Spring Public Health Conference. During the 2005 legislative session, a bill was passed allowing children to carry and self-administer asthma medication in school. (IB)

3. Caring Program for Children

The Caring Program for Children provides access to basic, preventive medical, dental, and vision coverage to low-income, uninsured Montana children. The Caring Program for Children is one of two programs under the Caring Foundation of Montana, Inc., a 501 (c)(3) non-profit organization whose administrative overhead is paid for by Blue Cross Blue Shield of Montana. To qualify for the Caring Program a working family must have income that is at or below 200 percent of the federal poverty level. Families who qualify for the Caring Program for Children have an average income slightly above the level required for public assistance, but far behind an income level that would allow them to purchase coverage on their own. Currently, 654 children from 46 Montana counties are enrolled in the program, with several hundred children on the waiting list. To date, the program has provided over \$2.7 million in medical care to more than 5,700 uninsured children. The Caring Program network includes more than 1,900 medical providers throughout Montana. (E)

4. Chemical Dependency Program

The Addictive and Mental Disorders Division administers the Chemical Dependency Program, which is funded through the Substance Abuse and Mental Health Service Administration Block Grant, Earmarked Alcohol Tax money and Medicaid. It provides outpatient and inpatient services to addicted youth and adults. There are two community based inpatient residential treatment providers and thirteen outpatient service providers. The program coordinates with state-approved substance dependency and abuse treatment programs under contract with the Division's Chemical Dependency Bureau to provide services. (DHC)

5. Child and Adult Care Food Program

The mission of the Montana Child and Adult Care Food Program is to influence healthy lifestyle choices by facilitating program participation and compliance, funding nutritious meals, and providing effective training. In Montana the program partners with approximately 120 childcare centers, which include Head Starts and non-profit/for-profit centers and after school programs and 1 adult day care. There are 12 Sponsoring Organizations, which monitor the facilities (day care homes and centers), provide training, offer technical assistance and resources, and pay claims or reimbursable meals to their facilities, with 1200 family day care homes. Last year the program reimbursed over 8.7 million meals that fed 27,000 children.

The CACFP is part of the National School Lunch Program and is open for participation to all children who are in child care outside of a residential setting (except for in shelters).

The center or day care home applies to be part of the program for reimbursement. It must be in compliance with Federal and State regulations for CACFP which means following the recommended meal patterns, following safe food handling procedures, completing required paperwork and record keeping, and completing required yearly training. The reimbursements to the child care provider depend upon the income eligibility of the children or in some cases the geographical area by school or census.

The Montana Child and Adult Care Food Program is coordinated by DPHHS. (E)

6. Children's Health Insurance Program (CHIP)

CHIP is a low-cost health insurance plan for eligible Montana children under the age of 19. The plan provides coverage for basic health needs, including medical, dental, and eyeglasses services. A child can qualify for CHIP based on household size and income.

In addition to meeting income guidelines, children cannot be eligible for Medicaid or currently be covered under other insurance. They must be Montana residents, and U.S. citizens or qualified aliens. Children cannot have parents or legal guardians employed by either the State of Montana or the Montana University System.

Parents are in charge of the health care their children receive. Some parents share in the cost of their children's health care by paying a small co-payment when care is received. CHIP is funded from both the state and federal governments. For every dollar the State of Montana provides in funding, CHIP receives over four dollars in federal matching funds.

The Health Resources Division within Montana's Department of Public Health and Human Services administers CHIP. CHIP contracts with Blue Cross Blue Shield of Montana to provide the insurance for children enrolled in the plan. DPHHS pays a premium for each child enrolled every month. CHIP enrollees receive an insurance identification card, an enrollee handbook, and lists of doctors, dentists, and other health care providers.

Prior to July 1, 2005, CHIP enrollment was limited to 10,900 children. CHIP insured this many children each month while maintaining a waiting list of approximately 400 children. In July 2005, additional funding was provided to CHIP as a result of an increase in the state tobacco tax. This money allows CHIP to increase its enrollment by approximately 3,000 children. The waiting list was eliminated July 1 and CHIP began enrolling additional Montana children who were previously uninsured. By increasing the number of children who have health insurance, Montana is making great strides in increasing children's access to health care services. (E)

7. Children's Special Health Services and Regional Special Health Clinics

The Children's Special Health Services (CSHS) section of the Healthcare Resources Bureau is responsible for the children and youth with special health care needs (CYSHCN) and for administering the funding for the CSHCN programs under the MCH Block Grant. CSHS provides limited financial assistance with the cost of services for

families of CSHCN who are under 200% of the federal poverty limit and are not Medicaid eligible. Families apply annually to receive support. Covered services include specialty physician care, diagnostic evaluation, pharmaceuticals, therapies, medical supplies and others as determined by condition. Financial assistance is available until funding is depleted. (DHC) CSHS provides assistance for treatment and management of physiological (structural) conditions such as cardiac disorders, cleft lip and palate, orthopedic conditions and chronic disorders such as seizure disorders, diabetes, and juvenile rheumatoid arthritis. This section provides and/or supports clinics across the State of Montana. These clinics include cardiac evaluation, cerebral palsy, spasticity management, rehabilitation, cleft/craniofacial, cystic fibrosis, diabetes, endocrine, gastrointestinal, genetic evaluation, juvenile rheumatoid arthritis evaluation, metabolic, muscular dystrophy, neural tube defects, spina bifida, neonatal intensive care follow up, neurology evaluation, and pulmonary.

In addition to CSHS, there are services available to children with special health care needs through the federally sponsored Part C/Early Intervention Program, the Children's Mental Health Program, school based EPSDT Medicaid Services, CHIP and the Montana Medical Genetics Program. These programs work together to provide Montana infants and children with special health care needs, and their family's comprehensive and appropriate intervention services.

CSHS provides and/or supports several multidisciplinary clinics across the State of Montana. These clinics include cleft/craniofacial and metabolic clinics. Services such as transportation, translation, family education and advocacy information, assurance of health care coverage, care coordination and case management referrals are provided through the specialty clinics as well as CSHS direct service contacts with families. Formal outreach services have been initiated during the past two years to the Montana AAP, Family Practice providers, public health meetings and Native American population.

CSHS is responsible for building systems of care for CYCSHCN. In the past, the CSHS section was involved primarily in the provision of direct care services for CSHCN. However, the section began a transition towards providing resource information and infrastructure building services over the last five years. CSHS partners with hospitals in the eastern and western regions of the state to support regional pediatric clinic sites. A total of 2141 pediatric specialty clinic visits were made during federal fiscal year (FFY) 2004. Regional pediatric clinic sites provide opportunity for CYSHCN to receive specialty care in their region, eliminating the need for most families to travel out of state. The clinic coordinators assist families with identifying needed resources for their children, coordinate services between a child's primary physician and specialty services and coordinate necessary follow-up after clinic. State CSHS staff provide training and serve as consultants to clinic staff in the provision of services and development of new services for CYSHCN. Need to establish a 3rd clinic site was identified during the past two years and funding has been approved which will allow CSHS to start the third regional clinic site during FFY 2006, thus assuring a regional clinic site for all regions of the state. CSHS has also provided diagnosis-specific conferences annually for health care providers, public health nurses, Part C providers, parents, school nurses, and other

school health providers. CSHS has developed an integrated software program (CHRIS) to assist with tracking and monitoring services for the CYSHCN population in Montana. CHRIS integrates CYSHCN data from several programs including the Regional Pediatric Clinic Sites, CSHS, the birth defects registry, and the Montana School for the Deaf and Blind. CHRIS links electronically to other data sources including birth certificates, SSI applicant data, and newborn hearing screening data. CSHS is increasingly aware that linking with Part C agencies would be very beneficial to coordinating and reporting services for CYSHCN. Additionally, CSHS staff met with the Office of Public Instruction (OPI) to revise/update the ten-year-old guidance manual for school nurses, personnel and administration serving children and youth with health needs in the school setting. The completed manual was distributed by OPI in May of 2005. It is anticipated training will take place during FFY 2006. (DHC, E, IB)

8. CJ Foundation for SIDS Grant

The FCHB has received two CJ Foundation for SIDS Grants since 1999. In 1999, a statewide parent network and support structure for families experiencing the death of an infant from SIDS was developed. In 2004, the CJ SIDS grant was used to develop and disseminate Native American SIDS risk reduction materials noting the risk factors. (PB)

9. Community Incentive Program and Community Incentive Program - Enhancement

The Community Incentive Program (CIP) was funded for three years through the Federal and State Incentive Grant. The ultimate goal of this program is to prevent substance abuse through a comprehensive and coordinated statewide risk-focused prevention delivery system designed to strengthen the healthy development, well-being and safety of Montana's children, families, individuals and communities. While funding no longer exists for this program, continued technical assistance in community mobilization, data, risk and protective factors can still be accessed.

The Community Incentive Program - Enhancement (CIPE) is funded for three years through the Federal State Incentive Grant awarded by the Substance Abuse and Mental Health Services Administration. The ultimate goal of this program is to prevent substance abuse through a comprehensive and coordinated statewide risk-focused prevention delivery system focused on 0-6 year olds designed to strengthen the healthy development, well-being and safety of Montana's children, families, individuals and communities. The Bureau provides continued technical assistance in community mobilization, data, risk and protective factors, implementation of evidence-based programs, and Prevention Specialist training can still be accessed.

(IB)

10. Diabetes Quality Improvement Program

The Diabetes Quality Improvement Program is part of Montana's Diabetes Control Program, which is funded through the CDC, Division of Diabetes Translation. The program works with primary care practices to implement the Diabetes Quality Care Monitoring System (DQCMS) software program. Implementation involves installing the system, training staff and assistance in developing and employing quality improvement

interventions. The DQCMS monitors diabetes patient populations and collects and disseminates quarterly aggregate data from sites participating in the program, which allows practices to assess their practice patterns and focus in on areas for quality improvement and assists the state in determining how care for people with diabetes is improving. (IB)

11. Dental Care – Medicaid

Dental care services through Medicaid provide dental care and check-ups for children on Medicaid. (DHC)

12. Developmentally Disables Waiver Program/Medicaid

The Developmentally Disabled (DD) Waiver was initiated in 1981. The state ‘waives’ certain federal requirements associated with Medicaid funds in approved waivers. From 7/1/00 to 6/30/01, \$36,769.692 in Medicaid Title XIX services were purchased for more than 1,300 persons with DD in this waiver. Services were provided to more than 200 hundred children with DD and intensive support and health care needs. The majority of these children live at home. The average per capita cost for persons served in this waiver program was approximately \$27,000 in FY 2001, excluding the cost of any state plan services accessed by the recipient. (E)

13. Domestic Violence Prevention Enhancement and Leadership through Alliances (DELTA)

Montana is one of fourteen states to participate in the Domestic Violence Prevention Enhancement and Leadership Through Alliances Program (DELTA). CDC Injury Prevention and Control originates the funds and the Montana Coalition Against Domestic & Sexual Violence (MCADSV) manages the program in Montana. DELTA is a capacity-building program working from the local level up to the national level to prevent domestic violence from occurring. Local communities participate through Coordinated Community Response (CCR) teams and develop their own plan to implement and/or enhance domestic violence prevention activities. This is complemented at the state level through a statewide DELTA advisory council and at the national level through collaboration with the CDC and thirteen other DELTA partners. (IB)

14. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT covers preventative well-child checkups for children ages birth through 20 who are enrolled in Medicaid. Well-child check-ups include physical, vision, dental and hearing screenings, risk assessments, immunizations, lab tests, including blood lead levels, and anticipatory guidance (health education). Referrals are made for additional services, including mental health, vision and dental, if the well-child check up indicates additional treatment is necessary. The visits are recommended to take place when the child is: 2-3 days old, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, 5 years, 6 years, and every two years subsequently, through age 20. During state fiscal year 2004, 65,079 Montanans were eligible for EPSDT and 47,659 screenings were provided. In addition, EPSDT provides for the coverage of any medically necessary treatment for children age birth through 20, even if that service is not specifically stated as a covered service in the Medicaid State

Plan. EPSDT is administered through the Montana Medicaid program, located in the state Department of Public Health and Human Services. (DHC, E)

15. Early Childhood Comprehensive System (ECCS)

The purpose of the Early Childhood Comprehensive System funding is to plan, develop, and ultimately implement collaborations and partnerships to support families and communities in their development of children who are healthy and ready to learn when they enter school. Funding is through the federal Maternal and Child Health Bureau and the Montana ECCS process is co-coordinated through the Family and Community Health Bureau (FCHB) and Early Childhood Services Bureau (ECSB) of DPHHS.

The goal of ECCS is to design a plan for an Early Childhood Comprehensive System (ECCS) in Montana that will include access to medical homes, mental health and social-emotional development, early care and education, parent education and family support. Montana is addressing this goal by:

- 1) Developing a leadership partnership to develop, implement, and monitor a plan for ECCS in Montana.
- 2) Developing a plan for ECCS in Montana, which addresses the health, psychosocial development and early learning experiences needed by young children.
- 3) Developing an implementation plan for Montana ECCS.

A grant application for additional ECCS planning funds was submitted in 2005. (IB)

The internal and external environmental scans completed as a part of Montana's ECCS process are included in Appendices G and H.

16. Environmental Public Health Tracking

The Montana Environmental Health Tracking Project (EPHTP) began in 2002 when Montana was awarded a three-year planning grant by the Centers for Disease Control and Prevention. EPHTP conducts pilot projects and uses previously-collected data to investigate the relationship between health and environmental hazards and risk factors in Montana and prevent and control the effects. Exposure to many of the hazards, including lead and mercury, can have serious health affects for women and children. (IB)

17. Family and Community Health Advisory Council

The Family and Community Health Advisory Council (FCHB AC) was formed in 1999 to advise the Family and Community Health Bureau (FCHB) and the Department of Public Health and Human Services (DPHHS) on matters impacting Montana's maternal and child health populations. The Council assists in interpretation of local, state and national information relating to the health of mother and children, identifies problems related to delivery of services, access to services or the quality of services available to mothers and children, acts as advocates for the services provided by the FCHB and makes recommendations to improve services to families and children in Montana. The FCHB AC includes representatives from agencies throughout the state, including direct

care providers, county health departments, WIC, state chapters of national organizations, family planning agencies, education, and state-specific MCH programs. (IB)

18. Family and Community Health Bureau

Montana's maternal and child health services are administered within the Family and Community Health Bureau (FCHB) of the Department of Public Health and Human Services. There are 30 staff members in the four sections of the FCHB: Child, Adolescent and Community Health (CACH), Maternal Child Health Data Monitoring, WIC/Nutrition, and Women's and Men's Health.

The FCHB administers the following federally funded programs:

- Maternal and Child Health Block Grant
- Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Title X Family Planning Program
- State System Development Initiative project, which supports standardized reporting of MCH services through the Public Health Data System (PHDS)
- Universal Newborn Hearing Screening Program
- Early Childhood Comprehensive System (ECCS)
- Birth Defects Registry
- Coordinated School Health Program
- Pregnancy Risk Assessment Monitoring Survey (PRAMS)

The FCHB administers the following state general fund programs:

- Contracted Clinical Genetic Services Program
- Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) and Public Health Home Visiting (PHHV)

(IB)

19. Family Planning Services

The Montana Statewide Family Planning Program contracts with 15 local agencies to provide family planning services in 29 locations. Family planning clinics are not located in every county, but education and clinical services are available throughout the state. Services are available to everyone, regardless of their ability to pay, with an emphasis on providing services to low income families and those who would otherwise have difficulty accessing family planning resources. All 15 family planning programs are designated STD programs. Medical services provided at family planning sites include physical exams, breast and cervical cancer screening, STD/HIV testing and STD treatment, anemia screening, pregnancy testing and counseling, and temporary and permanent birth control methods. Education and counseling topics offered at the agencies include reproductive health, breast and testicular self-exam, birth control, STD/HIV risks, infertility, and referral and linkages with community services. The range of services available at each site is dependent on financial and staff capacity.

The Family Planning Program is managed through the Women's and Men's Health Section of the Family and Community Health Bureau (FCHB) in DPHHS. Funding is

provided through federal Title X, MCH block grant funds and Preventive Health block grant funds. (DHC, E, PB)

20. Fetal Alcohol Prevention Program

The Fetal Alcohol Prevention Program (FAPP) was initiated in September of 2000 as part of a federal, three-year, congressional earmark for Montana, South Dakota, North Dakota and Minnesota. The Center for Substance Abuse Prevention administered \$3 million dollars per year to develop a three-component effort, which includes:

1. The creation of a Four State Fetal Alcohol Syndrome (FAS) Consortium, charged with program development, implementation and evaluation
2. Assessment which includes gathering of consistent data with which to accurately assess the incidence and impact of FAS in the region
3. Intervention projects, focused on the prevention of FAS and fetal alcohol effect (FAE).

Montana's intervention is built upon the Public Health Home Visiting Program (previously MIAMI), adding intensive home visiting and case management for pregnant women at risk of having a child with fetal alcohol syndrome or fetal alcohol effect (FAS/FAE). The project enabled Montana to partner with Dr. Phillip May, a researcher from the University of New Mexico to provide FAS evaluation clinics in the state. The first of six three-day FAS diagnostic clinics were held in 2002 in Great Falls and at the Blackfeet Reservation. The families received follow-up case management. As of 2004, funding was no longer available for the program and it has been discontinued. The Fetal Alcohol Spectrum Disorders Project was initiated in 2004 and will expand on FAPP. (E)

21. Fetal Alcohol Spectrum Disorders Project

The Montana FASD project began in 2004 through a subcontract through SAMHSA's *Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence* and focuses on FASD prevention, identification, and treatment referral. Montana's intervention will expand on the FAS Prevention program developed through the Four State Consortium and will add support specialists to PHHV teams at selected sites. PHHV team members will be trained to observe for signs and symptoms of FASD and make referrals as needed to multidisciplinary diagnostic teams. Montana will continue collaborative relationships with Shodair Children's Hospital Genetics Department and the University of New Mexico Center on Alcoholism, Substance Abuse and Addictions (CASAA) to provide diagnostic clinics to improve the identification of children with FASD conditions. The PHHV teams will also provide case management and appropriate referrals for treatment through Montana's Children with Special Health Care Needs program.

Project goals are to:

- Achieve a reduction in the incidence of women using alcohol while they are pregnant, thereby reducing the numbers of children born with FASD
- Improve the functioning and quality of life of children exposed to alcohol prenatally.

(E)

22. Fetal Alcohol Syndrome Advisory Council

The Fetal Alcohol Syndrome (FAS) Advisory Council was established to assist the state in implementing programs and services that may decrease the incidence of FAS in Montana. The Council provides the leadership required to recommend public policy to the Governor and Department Directors concerning fetal alcohol spectrum disorder (FASD) prevention in Montana. They are actively involved in the development of a strategic plan for FASD prevention, identification, and treatment. The Department of Public Health and Human Services organizes statewide FAS Advisory Council meetings. The Council consists of key stakeholders representing health professionals, service providers, state agencies, tribal populations, and individuals with FAS or their families. Tribal officials designated tribal members to participate in the Council. All other members are appointed by the Governor, and are recommended by the Department of Public Health and Human Services in response to written inquiries of participation. The Department of Public Health and Human Services provides staff support. (IB)

23. Fetal Infant Child Mortality Review (FICMR)

The Fetal, Infant and Child Mortality Review (FICMR) was initiated in 1997 as a statewide effort to reduce preventable fetal, infant and child deaths by making recommendations based on lessons learned from reviews of the deaths. The FICMR process brings together a multi-disciplinary team of community members to review de-identified, fetal, infant and child deaths. The community level review team is composed of health, social service, law enforcement, coroners, and other experts. Fifty-three of Montana's 56 counties and 6 of 7 Indian Reservations participate in FICMR reviews. The community level teams examine the case summary, identify issues and makes recommendations for community or statewide change. In 2001 and 2002, teams reviewed 81% of statewide fetal, infant and child deaths in Montana.²⁹

The state FICMR team mirrors the membership of the local FICMR teams. It assists the local community teams to identify, address and potentially decrease the numbers of preventable deaths by making recommendations for needed policy or legislative changes, examining statewide trends and issues, and supporting prevention activities at the state and local level. (IB)

24. Follow-up of Abnormal Newborn Screenings and Hearing Screenings

CSHS nurse consultants provide follow-up of abnormal newborn screening (including hearing) results to assure children receive appropriate professional care. Nurse consultants link families to local resources, medical and therapeutic services and initiate enrollment into the specialty clinic program. Without immediate follow-up, families may not access services within a critical time period. (E)

25. Genetics Program

The Genetics Program contracts with Shodair Children's Hospital to offer testing, counseling, and education through:

- Comprehensive genetic services to all areas of the state and all segments of the population

²⁹ Montana Fetal, Infant and Child Mortality Review, December 2004.

- Development of counseling and testing programs for the diagnosis and management of genetic conditions and metabolic disorders
- Development and expansion of educational programs for physicians, allied health professionals and the public with respect to:
 - The nature of genetic processes.
 - The inheritance patterns of genetic conditions.
 - The means, methods and facilities available to diagnose, counsel and treat genetic conditions and metabolic disorders.

(DHC)

26. Head Start/Early Head Start

Head Start is a comprehensive child development program that serves low-income children birth to 5 years of age, pregnant women and their families. The goal of the program is to increase school readiness among children from low-income families. Programs provided by Head Start and Early Head Start Agencies include: referrals and links to community services and resources, adult education, child safety and nutrition, community advocacy, crisis assistance, early childhood education, family goal setting, family and community partnerships, health and dental screenings and referrals, assistance identifying a medical home, job skills training, mental health services and referrals, parent involvement, parenting education, program management and design, staff training and development, transition services and transportation. Fifty-two of Montana's 56 counties have Head Start Programs. In 2002, 4,710 children and 68 pregnant women were enrolled in Head Start programs. The majority of children were on Medicaid or without insurance. (E)

27. Healthy Mothers, Healthy Babies

The Montana Coalition of Healthy Mothers, Healthy Babies received the Covering Kids & Families Grant in 2003 from the Robert Wood Johnson Foundation to connect Montana's uninsured children with low-cost or free health care coverage through CHIP, MEDICAID, and other programs. The funds support advocacy tools to educate the families about various insurance options for their children. This includes participation in a nationwide Back to School outreach campaign about insurance options available to children. In addition, this program helps coordinate state and local efforts to expand children's access to health coverage. (E)

28. Idea Project

The Information for Data Evaluation and Assessment (IDEA) was designed and implemented by the Health Policy and Services Division of the Montana DPHHS beginning in 1998 to provide improved support for the delivery of maternal and child health-related services at the state's local public health departments and to improve local and state capability for evaluation of program effectiveness. It was initially funded through federal funds from the Maternal and Child Health Bureau, Health Resources and Services Administration, DHHS, CDC, and the U.S. Department of Agriculture, Food and Consumer Service. The primary emphasis was to provide local capability for immediate benefit to clients and local health professionals and to generate required

federal reporting for use of MCHBG funds. The IDEA project was planned in three developmental stages.

1. The first phase consists of the Public Health Data System (PHDS) that serves local health departments by recording current client case management and providing tracking capability. The PHDS was initially designed to support four of the public health programs provided at the local level: client case management and tracking; an initiative to service women with high-risk pregnancies; family planning; and immunizations. This has been “rolled out” to 52 of the 54 health departments in the state.
2. The second phase is a web-based program titled Sharing of Public Health Information (SOPHI). It was designed to link the PHDS and other health data systems used at the local level, e.g., WIC, the CMX system for Family Planning, Medicaid Eligibility Determination offices, and the data system used by the Indian Health Service for public health information. SOPHI provides the capability to share the client’s demographic information with client authorization between all of these data systems at the local level, thus eliminating duplicate interviewing and input. In addition, it will facilitate client-authorized referrals between programs available in the local service area and statewide. This capability is currently unused due to the difficulty of use with original, archaic WIC software and the cost of establishing interfaces with other software.
3. The IDEA Information Center (InfoCenter) was initially planned as a data warehouse component, but was abandoned due to prohibitive cost and the availability of newer analysis capability on an ad hoc basis. Extracts of de-identified data from statewide systems such as Medicaid, Vital Statistics, and Medicaid eligibility determination will be linked with extracts of de-identified local data from the IDEA system in order to perform comprehensive evaluations at the county, regional and state levels.

The IDEA system has been administratively assigned to the Informatics Section in the Public Health and Safety Division (formerly the Health Policy and Services Division) for management with other Division systems. (IB)

29. Indian Health Services (IHS)

The Indian Health Services (IHS) Office in Billings oversees the health services provided to Native Americans in Montana. The program serves nearly 52, 013 Indian people in seven reservations. All Service Units, with the exception of the Flathead Tribal Service Unit, provide direct ambulatory, emergency, dental, environmental health, community health and preventive health services. The Flathead Tribal Service Unit provides direct pharmacy, dental services and limited physician services. All other medical services are provided through contractual arrangements with physicians and hospitals in various communities. Blackfeet, Crow, and Fort Belknap have hospitals that provide both inpatient and outpatient care. The Confederated Salish and Kootenai Tribes have compacted the Flathead Service Unit under Self-Governance. The Rocky Boys Service Unit operates under Self-Governance as well. The following table lists the health facilities at each reservation.

Indian Health Services - Service Providers Per Service Unit

IHS Service Unit	Health Services
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Blackfeet Service Unit	<ul style="list-style-type: none"> -IHS Indian Hospital -IHS Health Center including a Dental Clinic -Blackfeet Primary Residential Treatment Center for chemical dependency patients -Blackfeet Tribal Dialysis Center
Crow Service Unit	<ul style="list-style-type: none"> -Crow/Northern Cheyenne Indian Hospital -Lodge Grass Health Center -Pryor Health Station -Urban Health Clinic located in Billings
Fort Belknap Service Unit	<ul style="list-style-type: none"> -Fort Belknap Hospital -Fort Belknap Health Center -Eagle child Health Center
Fort Peck Service Unit	<ul style="list-style-type: none"> -Verne E. Gibbs IHS Health Center -Poplar Community Hospital -Popular Nursing Home -Chief Redstone IHS Health Center -Faith Lutheran Home -Trinity Hospital -Fort Peck Tribal Dialysis Center -Spotted Bull Treatment Center -Fort Peck Indian Youth Services Center
Northern Cheyenne Service Unit	<ul style="list-style-type: none"> -Lame Deer Health Center -Dental Clinic – St. Labre Indian School
Flathead Tribal Service Unit	<ul style="list-style-type: none"> -Flathead Tribal Health Center -St. Ignatius Medical Clinic -Polson Medical Clinic -Elmo Medical Clinic -Ronan Medical Clinic -Pablo Dental Clinic -Polson Dental Clinic -St. Ignatius Dental Clinic
Rocky Boy Service Unit	<ul style="list-style-type: none"> -Chippewa-Cree Health Center

In addition to the health services located on the reservations, there are five urban clinics serving the Native American population. These are: Indian Health Board of Billings, Helena Indian Alliance, Native American Center Incorporated (Great Falls), Missoula Indian Center, and North American Indian Alliance (Butte). Three of the urban facilities provide limited primary medical care services, in addition to outreach, referral, health education, transportation, limited mental health services and substance abuse counseling services. The other two programs provide outreach and referral, health education, transportation and substance abuse treatment. The transportation component is an integral part of the urban health care delivery system since it transports patients to reservation-based health programs. (DHC)

30. Medicaid

The Montana Medicaid program pays medically necessary health care costs for people who demonstrate financial and medical need. This insurance program covers the blind, disabled, children and pregnant women who have family incomes and resources below the limit for their category determined primarily by the Federal Poverty Level (FPL). The state administers this program and is responsible for determining eligibility of recipients and payment to providers for covered services. Medicaid services are funded by a federally determined formula that combines state and federal revenues at

approximately a 30% state and 70% federal dollar split (except that Indian Health Service and Tribal Health costs are 100% federally funded). Most administrative costs are split 50/50 between state and federal dollars.

Low-income pregnant women are eligible for Medicaid if their family income is less than 133% of the FPL and their resources do not exceed \$3,000.

- Premature or very low birth weight babies incur costly direct medical expenses. The average estimated cost to Medicaid for a high-risk premature infant is \$33,973.
- Unintended pregnancy costs Medicaid approximately \$8,716 for prenatal care, delivery and newborn pediatric care. This compared to \$156 per person per year for family planning services is costly for the program.

Medicaid is the largest provider of health coverage for infants and children in the State of Montana. The program covered a variety of services for 83,336 children as of April 2004. Infants and children through the age of five are provided full coverage under the Medicaid program if the family income is less than 133% of the FPL. Beginning October 1, 2001 with the Omnibus Budget Reconciliation Act 89, all children age eighteen and younger are covered if the family earnings are not greater than 100% FPL. (E)

31. Mental Health Program

The Addictive and Mental Disorders Division provides Medicaid funded mental health services through community providers. It served 9,419 youth in SFY 2002. The community providers deliver services such as therapies, day treatment, rehabilitation and support, care coordination and case management services. The program provides inpatient and outpatient hospital services and out-of-home care services including residential treatment, therapeutic foster and group care.

The 2003 Legislature effective July 1, 2003 moved children's mental health from the Addictive and Mental Disorders Division to the newly created Children's Mental Health Bureau (CMHB) within the newly created Health Resources Division (HRD). The Children's Mental Health Bureau, Children's Health Insurance Plan (CHIP) Medicaid child and family medical services are included within the new Division. CMHB is responsible for designing, managing and evaluating the children's Medicaid mental health service plan, and the Children's Mental Health Service Plan (CMHSP). CMHSP is a capped plan for youth with serious emotional disturbance who are not eligible for Medicaid or for CHIP and whose family gross income is within 150% of the federal poverty guidelines.

The Children's Mental Health Service Plan was funded by the 2003 Legislature to serve approximately 130 youth with serious emotional disturbance in each year of state fiscal years 2004 and 2005. The plan is limited to outpatient mental health services.

DPHHS's Health Resources Division (HRD) and Children's Mental Health Bureau are responsible for the development of a mental health system of care to serve youth with serious emotional disturbance and their families (52-2-302 and 52-2-304 MCA). To

assist with the planning and implementation of the system of care, the legislature established the Children's System of Care Planning Committee (SOC's). This committee meets quarterly. The committee includes over 30 members representing, but not limited to: state and local communities, parents of youth with SED, providers of mental health services, advocates, legislators, Native Americans, juvenile justice, youth court, child welfare, Office of Public Instruction, mental health, and Mental Health Oversight Advisory Committee (MHOAC). Among the responsibilities assigned to the committee by the legislature (52-2-304 MCA) are: develop policies aimed at eliminating or reducing barriers, promote development of an in-state quality array of core services, advise local agencies, encourage the development of local interagency teams (Kids Management Authorities (KMA's), and coordinate development of a stable system of care for high-risk children with multi-agency service needs (youth with serious emotional disturbance). (DHC)

32. Mentoring 2Quit

Healthy Mothers Healthy Babies began Mentoring to Quit – M2Q, which is a smoking cessation program that pairs women, some who have quit smoking, with current smokers. The program was written and designed by HMHB in collaboration with the March of Dimes. It began with a pilot project grant of \$5,000 in Butte Health Department, which was successful and the department has continued to use the program. HMHB hopes to gain more funding to expand this program. (E)

33. Montana Birth Outcomes Monitoring System (MBOMS)

The Montana Birth Outcomes Monitoring (MBOMS) began in February of 1999 to allow identification and surveillance of newborns and infants with targeted birth outcomes, specifically neural tube defects, cleft lip and/or palate, congenital heart defects and congenital hypothyroidism. The program expanded to collect data on 45 defects endorsed by the CDC. MBOMS relies on the providers to submit data on the occurrence of these conditions since the State of Montana does not mandate reporting. This program also runs a referral network for the children's families. Direct referrals are possible through Montana's CHCSN program, which offers medical and financial assistance to eligible families. Families are also referred directly to the state Medicaid and CHIP. Outside medical referrals to the Montana Medical Genetics Program for genetic consultations, risk-recurrence assessment and medical genetic services are also possible through MBOMS. (IB)

34. Montana Coalition Against Domestic and Sexual Violence

The Montana Coalition Against Domestic and Sexual Violence (MCADSV) supports and facilitates networking and collaboration among member organizations while advocating for social and systems change to eliminate sexual and domestic violence in Montana. MCADSV includes 41 domestic and sexual violence programs, 12 Crime Victim Witness Programs and 103 individual representatives from law enforcement, mental health, children's services, batterers' intervention programs, campus programs and low-income advocates. Fifty of the sixty-one domestic violence programs in the state are part of the Coalition.

MCADSV provides domestic violence training covering various fields. The organization provides training to:

- The judicial system in conjunction with the Montana Attorney General's Office
- New law officers – Montana Law Enforcement Academy
- New victim/witness advocates – Montana Law Enforcement Academy
- Domestic and sexual violence advocates through Advocate Institute
- Professions: nurses, educators, mental health professionals, and clergy

MCADSV provides infrastructure services to their member organizations through technical assistance and networking. In addition, the Coalition works on domestic and sexual violence policy by coordinating policy development at the national and state level. (IB)

35. Montana Council for Maternal and Child Health

The Montana Council for Maternal and Child Health (MCMCH) was initiated in 1987. MCMCH develops a "Children's Agenda" every two years by planning sixteen to eighteen community forums every two years bringing together health providers, social service providers and other stakeholders in the maternal and child health area. These forums set the priorities for the upcoming legislative session. The purpose of the Council is to promote the well being of children by identifying needs and providing education about the services considered vital to Montana's children and families. Members include representatives from State agencies, county agencies, professional organizations, non-profit organizations, and health care providers. (IB)

36. Montana Oral Health Alliance (formerly Montana Dental Access Coalition)

The Montana Dental Access Coalition (MDAC) was established in 1999 during the first Montana Dental Summit to engage Montana in the National Oral Health Initiative and to develop strategies to increase dental access for the underserved. Subsequently, workgroups were formed, a second summit held, and an action plan was developed to include legislative agendas for the 2000 and 2002 legislative sessions. In 2004, a strategic oral health plan was developed and a state-based oral health surveillance system was made a priority. The MDAC's name was changed to the Montana Oral Health Alliance given that the goals of the coalition have expanded beyond oral health access issues. (IB)

37. Montana Safe Kids Safe Communities

The Montana Safe Kids Safe Communities program is funded through the Montana Department of Transportation and the National Highway Traffic Safety Administration and coordinated by Healthy Mothers Healthy Babies. This program is uniquely driven by local coalitions. This initiative has three components related to traffic safety. They include education on seatbelt usage and child passenger safety (car seat usage and installation) and education on driving under the influence. (PB)

38. Montana Safe Kids Campaign

Montana's Safe Kids Campaign is a public education campaign coordinated by Healthy Mothers Healthy Babies with information on water safety including boating safety, proper life jacket use, swimming pools, and other subjects related to childhood safety issues. (PB)

39. Montana's Child

The Montana's Child Project serves as a single point of contact for Montana families to learn more about maternal and child health issues and related services. The program is coordinated by Healthy Mothers, Healthy Babies (HMHB) and provides no cost education as well as referral to services. A 1-800 number allows individuals to speak directly with a HMHB staffer based in Helena with questions and advice on issues related to pregnancy, child health and maternal health. Phone contact may provide referral to local services, disseminate information through follow-up mailings, and answer specific childcare questions. It is currently supported through general operation funds and fundraising. (PB)

40. Montana Strategic Suicide Prevention Plan

In January 2001, the Montana Strategic Suicide Prevention Plan was released, and the language was updated in May of 2005 to include youth-specific language. The Adolescent Health Coordinator within the Montana DPHHS, as well as other DPHHS staff, collaborated with statewide stakeholders to develop and update the plan. (IB)

41. Newborn Hearing Screening

Montana has a voluntary universal newborn hearing screening program. Birthing facilities that participate in this program must report their hearing screening results to the state's Newborn Screening Monitoring program. One hundred percent of the state's birthing facilities participate in this program, which was begun in 2001. Hearing screening equipment was purchased through use of grant funds to ensure that all birthing facilities in the state could accurately screen all newborns. Children that fail to pass their initial and repeat hearing screening are referred to audiologists for diagnosis. These audiologists also provide their diagnostic results to the child's medical home and the state's Newborn Screening Monitoring program. Infants identified with a moderate, severe or profound hearing impairment are tracked by the Montana School for the Deaf and Blind in accordance with their legislative mandate to ensure appropriate interventions are made. Staff in Children's Special Health Services provide information to parents of children with mild diagnosed hearing loss.

90% of the babies born during 2003 were screened for hearing loss prior to hospital discharge. All 36 of the birthing facilities in Montana did universal hearing screening at the end of December 2003. Of the newborns screened and reported, 6% did not pass prior to the hospital discharge. Of all the infants identified with permanent hearing loss, 32% received appropriate early intervention by 6 months of age, 43% began appropriate early intervention after 6 months of age and the intervention status of 25% of the population is unknown. (PB)

42. Newborn Screening Monitoring Program

The birthing facilities or the person responsible for registering the birth of an infant are required by administrative rules with the force of law to ensure that each infant is tested for Phenylketonuria (PKU), galactosemia (GAL), congenital hypothyroidism (CH), and hemoglobinopathies.

Management of the newborn heelstick screening program is a cooperative effort within Montana's birthing facilities and programs within DPHHS involving the Montana Public Health Laboratory (MPHL) and the Family and Community Health Bureau within the Division of Public Health and Safety and the Health Care Resources Bureau in the Child and Adult Health Resources Division. Birthing facilities or the person having responsibility to register the birth of an infant have statutory responsibility to ensure that each infant is tested in accordance with DPHHS rules. The required tests are sent to the Montana Public Health Lab (MPHL) for processing. If abnormal results are found, the MPHL notifies the responsible agency/party that a repeat test must be performed. If abnormal PKU or galactosemia test results are discovered, an immediate referral for case management is made by the Newborn Screening Monitoring program in the FCHB to Children's Special Health Services in the Health Care Resources Bureau. The Newborn Screening Monitoring program monitors compliance of the birthing facilities with their screening responsibilities and provides state screening reports to the appropriate agencies. Montana is monitoring national efforts to recommend additional screening tests in the future. (PB)

43. Oral Health Screenings

Volunteer dental and health professionals conducted a total of 29,246 screenings representing 31 counties and 88 schools during the 2002-2004 school years. A network of school screening coordinators plan, coordinate, and assist in follow-up referral efforts for children presenting with urgent and non-urgent dental needs. During the 2005-2006 school year, Montana will be collecting data from a controlled sample of Montana third graders in 30 schools statewide to better estimate the prevalence and need for dental care and accurately respond to sealant prevalence rates. The screenings identify students with pain or imminent pain who need urgent dental care or need dental treatment soon, make students and parents/guardians aware of oral health status, and allow the collection of oral health data. (PB)

44. Part C/Early Intervention

Part C/Early Intervention is a federally funded program with the mission to assure that all Montana infants and toddlers with disabilities, and their families have the right to comprehensive, and appropriate intervention services. These services should recognize the family as the lead members of the team, and be responsive to the family's needs and dreams for their child. A goal of the Part C program is to enable families to become effective lifelong advocates for their children who have developmental disabilities or delays. The following services are available to children who are eligible for assistance through the Infant and Toddler Program:

- Early identification, screening and assessment (including medical services for diagnostic evaluation purposes)

- Special instruction
- Parent and family education, training and counseling services
- Speech pathology and audiologist services
- Physical therapy and occupational therapy
- Psychological services
- Support coordination and social work services
- Health services (necessary for the child to benefit from early intervention services) and nursing services
- Nutrition services
- Vision services
- Assistive technology devices and services
- Transportation and related costs

The Developmental Disabilities Program, of the DPHHS administers the Part C/Early Intervention program. There are currently seven regionally based Part C agencies across the state, to provide services to families. The federal government mandates that all children that would be considered eligible for this program are included in the program; therefore, there are no income requirements for these services. Eligibility for the program is determined by the child having:

- An established condition which is very likely to result in a developmental delay – even if the delay does not currently exist; and,
- A significant delay of 50% in one developmental area or 25% in two or more of the following areas:
 - Communication development
 - Physical development, including vision or hearing
 - Social or emotional development
 - Adaptive development
 - Cognitive development

The majority of the PartC/Early Intervention program funding provides services for children from birth to age three. Part C usually serves as the link between families and schools, by helping with the transition into school-based services, such as special education.

Part C and CSHS Collaboration: Part C and CSHS work together in several ways. The following is a list of ways in which the two agencies combine efforts.

- Provide mutual referrals across agencies (CSHS and Part C) for children/families who may need, or be eligible for services provided by the different groups
- Emphasis in discussions with families is on the concept that children need a medical home (usually a primary care physician, with the assistance of public health staff) where all of their medical service needs can be tracked and met
- Mutual invitations to training events of interest to both Family Support Specialists (Part C) and Public Health Nurses
- Telephone, email, or on-site technical assistance/training at the request of either public health or Part C agencies or staff

- Ongoing (negotiated every three years) formal interagency agreement on coordination of services and responsibilities of each state agency involved in early intervention services, including the Health Policy and Services Division, CSHS, Part C, and the Office of Public Instruction
- The program manager of CSHS is a member of the Part C advisory council (E, IB)

45. Perinatal Substance Abuse Prevention Program

The Perinatal Substance Abuse Prevention Program's (PSAP) role is to coordinate state programs and services related to the prevention of prenatal alcohol, tobacco, and illegal drug exposure. This includes finding funding sources and coordinating, monitoring, evaluating, and providing technical assistance and training to prevention projects. PSAP is also working collaboratively with the Public Health Information section to improve data collection on substance use in pregnancy. Montana's Family and Community Health Bureau in the Department of Public Health and Human Services is currently coordinating the SAMHSA FASD subcontract and maintains and coordinates the statewide FASD Advisory Council and subcommittees. (PB)

46. Prenatal Care

This prenatal care occurs in the county health departments and includes any direct service or procedure provided to a pregnant woman. (DHC)

47. Protect My Air

The Child Health Coordinator within the Family and Community Health Bureau and the Day Care Licensing Section in the Quality Assurance Bureau initiated a Healthy Indoor Environment Project for Day Cares called "Protect My Air." Day Care inspectors will assess the indoor environment of daycares during their routine inspections, and provide information on remediation of identified problem areas. This will benefit all children in daycares, and especially children with asthma. (IB)

48. Public Health Home Visiting Program

The Montana Initiative for the Abatement of Mortality in Infants (MIAMI) program began in 1989. This program is still referred to in statute as MIAMI, but in practice is called Public Health Home Visiting (PHHV). This program serves high-risk pregnant women, which includes approximately twenty percent of the pregnant population in Montana. The state administers 16 contracts with local agencies to provide home visiting services. Funding for PHHV comes primarily from the state, although some MCH Block Grant funds also go towards home visiting services at the county level. The PHHV/MIAMI program serves approximately 1,400 high-risk women – 13% of the pregnant population – and their families each year in 33 counties and 6 reservations.

The objectives of Montana's Public Health Home Visiting Program are to:

- Improve pregnancy outcomes
- Improve family functioning
- Monitor and improve the home environment of pregnant women and infants, considering environmental, economic, psychosocial, and medical risks.

- Decrease the incidence and impact of drug and alcohol use and abuse

The local PHHV projects provide nursing, dietitian and social services, health education and advocacy for pregnant women. Health professionals at each PHHV site monitor the woman's pregnancy and outcome. A woman needing unique assistance will be referred to the appropriate agencies.

PHHV coordinated with Montana's Medicaid Program to develop the Targeted Case Management (TCM) for High Risk Pregnant Women and CSHCN. Participating providers must seek Medicaid TCM provider status and obtain Medicaid reimbursement for the TCM portions of the PHHV services. TCM includes case management, assessment, case plan development, care coordination, monitoring and referral for other services. (E, IB)

49. Quality Diabetes Education Initiative

There are 18 ADA- and 1 IHS- recognized diabetes education programs in Montana and 70 Certified Diabetes Educators. The Quality Diabetes Education Initiative offers resources to health care professionals seeking to improve and maintain their skills regarding diabetes education. The Initiative provides resources to assist health professionals in outpatient settings develop basic diabetes education programs and increases skills of individual educators through a self-study and peer-mentoring process tailored to the needs of the educator, clients and setting. In addition, the Initiative provides technical support to health care professionals in outpatient settings who want to develop a diabetes education program. (PB)

50. Rape Prevention Education

The Rape Prevention Program is designed to strengthen sexual violence prevention efforts by supporting increased awareness, education, training and the operation of hotlines. This program is funded through the National Injury and Violence Prevention Center in the CDC. Through 16 contractors, the program provides:

- Educational seminars
- Operation of hotlines
- Training programs for professionals
- Preparation of informational materials
- Education and training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities
- Education to increase awareness about drugs used to facilitate rape or sexual assault

Other efforts to increase awareness of the fact about, or to help prevent, sexual assault, including efforts to increase awareness in under-served communities and awareness among individuals with disabilities. (E)

51. Relief from Asthma Project (RAP)

The Relief from Asthma Program (RAP) for Medicaid children with asthma in partnership with Montana Medicaid began in March of 2002. The program was piloted

in seven sites and training was conducted for public health staff to provide the home-based case management services. Reimbursement for services was through the targeted case management program for CSHCN. Medicaid implemented a chronic disease case management program, Nurse First, and the RAP program was discontinued in 2004. (E)

52. Ryan White Care Act

The Ryan White Care Act provides financial drug assistance as well as primary health care for individuals living with HIV. Montana only receives funding from Title II and Title III of the Act. The program served 47 women in 2004. Title II services may include:

- Ambulatory health care
- Home-based health care
- Health Insurance/prescription drug coverage
- Medications (ADAP – AIDS Drug Assistance Programs)
- Case management
- Support services
- Outreach to HIV+ individuals who know their status
- Early intervention services

Title III services include:

- Risk-reduction counseling on prevention, antibody testing, medical evaluation and clinical care
- Antiretroviral therapies
- Protection against opportunistic infections and ongoing medical, oral health, nutritional, psychosocial and other care services for HIV infect clients
- Case management to ensure access to services and continuity of care for HIV-infected clients
- Attention to other health problems that occur frequently with HIV infection, including tuberculosis and substance abuse

(DHC)

53. Safe Sleep for Baby

The “Safe Sleep for Baby” project was initiated in 2002 by the Department of Public Health and Human Services with a \$1225 donation from Safeway Grocery Stores. Twenty-two at risk families were visited by public health home visiting nurses, who were not only able to provide these families with a safe sleep environment for their babies, but educated them about safe sleep environments and reducing the risk for Sudden Infant Death Syndrome. Again in 2003, with help from \$1500 donation from Safeway, sixteen families and babies benefited from the Safe Sleep for Baby project. In 2004, the Family and Community Health Bureau Safe Sleep for Babies Project developed a partnership with Healthy Mothers Healthy Babies, and with a donation from HMHB and Safeway, provided cribs and safe sleep education to 41 babies and their families. The need for cribs far exceeded the availability in all three years. (PB)

54. Safe Sleep Rules for Daycares

The Child Health Coordinator and Day Care Licensing Section in the Quality Assurance Bureau of the Montana DPHHS developed a licensing approach to mandating Safe Sleep Rules for infants in daycare. As a result, Administrative Rules of Montana have been developed that will require that healthy infants be placed on their backs to sleep, as well as other safe sleep requirements. (PB, IB)

55. School-Based Fluoride Mouth Rinse Program

The School-Based Fluoride Mouth Rinse program targets public and private schools for participation in Montana communities where the public water supply contains fluoride content below optimal levels to reduce dental decay. It is a free oral health program for K-12 students supported by MCH Block Grant funding. It is dispensed weekly to nearly 45,000 children in 274 schools and 39 counties each year through coordinated efforts with school staff, dental professionals and volunteers. The State's primary role is to dispense the resources through contractual services, provide technical assistance and consultation, and make recommendations for program retention and growth. (PB)

56. School-Based Health Screenings

School-based health screenings for vision, hearing, scoliosis and dental issues occur in some districts and schools throughout the state. Staff to conduct the screenings may be provided by the school district, school or county.

A survey is sent out annually to all counties in Montana that receive Maternal and Child Health Block Grant funds to assess MCH services provided by counties throughout the state. 2005 survey results indicate that 66% of the 53 counties surveyed provide some type of school health screenings in some schools in their county.

Montana counties providing school-based screening services 2005 Survey		
<i>Screening type</i>	<i>Number of Counties (n=53)</i>	<i>Percent of Counties</i>
Vision	33	62.3
Hearing	17	32.1
Dental	21	39.6
Scoliosis	18	34
Physical	3	5.7

Screenings may also be provided by school health nurses or school health services contracted from another source. Just over 50% of counties indicated that some of the schools in their counties have school nursing services other than those provided by the county. Such services may or may not include screenings. (PB)

57. Seven Sisters Native Coalition

Only three of the seven Indian reservations have a domestic violence shelter, and two reservations do not have any domestic violence services except minimally through the tribal courts or health services. The reservations that lack services or have minimal services are in extremely remote areas of the state without easy access to neighboring domestic violence shelters. Therefore, Native women residing on tribal lands in Montana

do not currently have the same kind of access to domestic violence services as their urban counterparts or non-Native women. Participants in the Tribal Women Summit (Indian domestic violence conference) submitted a successful grant proposal to the Tribal Domestic and Sexual Assault Grant Program, U.S. Dept. of Justice to start a Native American domestic violence coalition in Montana called the Seven Sisters Native Coalition. Its mission is to form better relationships between tribal domestic and sexual violence programs and improve services for reservation-residing Indian women and children who are abused. (IB)

58. Sexual Assault Program

The Sexual Assault Program attempts to prevent sexual assaults and to provide appropriate early intervention to persons who have been sexually assaulted. It is funded through the federal Preventive Health Services Block Grant administered through the CDC. Currently, there are 16 contracts funded to provide services, which include:

1. Maintaining a 24-hour answering service for those who have been assaulted
2. Providing immediate support services to survivors of sexual assault
3. Training volunteers
4. Presenting educational programs regarding sexual assault prevent and services

(ES)

59. SIDS: A Guide for Child Care Providers

A guide entitled “Sudden Infant Death Syndrome: A Guide for Child Care Providers” was developed and distributed to every registered childcare provider through collaboration with the twelve Resource and Referral Networks and through their registration renewal process. In 2003, an informational campaign directed towards the hospitals to model the correct sleeping position for infants was implemented. (PB)

60. Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

WIC provides nutritional education, specific nutritious supplemental foods, and often serves as the catalyst to entry into other needed health care and social services. Women who are pregnant, breastfeeding, or recently gave birth, infants (birth to 12 months), and children (one to five years of age) who meet residency requirements and live in a household with an income at or below 185% of the federal poverty level and determined by a health professional to be at medical or nutritional risk are eligible for the program.

There are an estimated 31,746 potentially eligible women, infants and children in Montana as of July 2004. Twenty-nine local programs provide WIC services to 56 Montana counties and seven reservations through 100 service sites. WIC checks are accepted in 280 Montana grocery stores. This results in over \$13 million of revenue per year to those businesses. The 2004 participation rate in WIC services statewide was 4,895 women, 4,330 infants and 12,077 children. This totals to 21,302 participants and approximately 70% of the potentially eligible are served. Montana’s WIC’s breastfeeding rates are higher than the national average, however, they are well below the Healthy People 2010 Objectives.

Participation in WIC has been demonstrated to contribute to fewer lower birth weight babies born, improved diets, reduced fetal deaths, higher immunization rates, and reduction in anemia. In addition, participation in WIC can lower Medicaid costs for mothers, newborns and the government. WIC serves as a catalyst to accessing other public health services. The State does not provide direct management of WIC services. However, WIC works closely with other Montana MCH programs, as they often serve the same clients. WIC is funded primarily by the U.S. Department of Agriculture with small amounts of state funding in 2004 and 2005.

Montana WIC Statistics as of May 25, 2004

	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004 (Preliminary)
Participation	21,346	21,288	21,413	21,402	21,320	21,302
Food Cost	7,885,168	8,547,312	8,774,269	8,696,885	8,716,997	9,317,432
Average Monthly Benefit Per Person (\$)	30.78	33.46	34.15	33.86	34.07	36.45
Nutrition Service and Administration Costs (\$)	4,178,202	4,292,192	4,557,377	4,184,429	4,401,615	4,338,473

*Taken from WIC - Program Data <http://www.fns.usda.gov/pd/wichome.htm>. Accessed 6/15/05.

(E, PB)

61. Strategic Prevention Framework State Incentive Grant (SPF SIG)

Montana was awarded July 1, 2005, a five year grant totaling \$11.66 million by the Substance Abuse and Mental Health Services Administration. This grant will focus on developing an Epidemiological Workgroup to identify priority areas to implement evidence based substance abuse prevention programs. The focus of the grant is underage substance abuse. (IB)

62. Suicide Prevention Hotline

Calls from Montana to the two nationwide suicide prevention hotlines are referred to a call center in Montana. The center offers crisis intervention services and referrals to callers. The call center is unfunded except for a small stipend (no state funding is provided) and is not marketed across the state because the center does not have adequate staff to handle an increase in call volume. The same call center provides crisis intervention and referrals for a local crisis line in one community. (E)

63. Suicide Prevention Mini Grants

In 2004 the Montana Governor's Office provided funding for mini grants for communities to partner with local Fetal Infant Child Mortality Review (FICMR) teams and the Indian Development and Education Alliance (IDEA) to reduce teen suicide, and

in 2005, Preventive Health Block Grant carry-over funds were used to fund continuing and new mini grants. (IB)

64. Statewide Immunization Efforts

County Health Departments provide immunizations for infants and children. Counties may choose to use MCH block grant funds to provide immunization programs. The fiscal management decisions concerning local health departments vary for each county and the counties have the autonomy to spend their funds in the way they choose. Geographical distribution of public health services across the state varies based upon county appropriation of funds. The DPHHS provides an immunization registry database to track immunization and provides training and support for the registry. The public clinics make federally provided vaccine available to clients unable to afford the cost of the vaccine and administration through the Vaccines for Children Program (VFC).

65. Targeted Case Management – Medicaid

The Targeted Case Management Services works with Medicaid to provide services. The target population is divided into five groups:

1. CSHCN
2. Seriously emotionally disturbed children
3. Developmentally disabled 16-18
4. Chemically dependent
5. Children at risk of abuse or neglect

CSHS has been involved with the task force composed of representatives from state agencies serving the 5 specified groups listed above to update guidance and the state plan for Targeted Case Management for CYSHCN. During 2004 the program manager for CSHS provided on-going training to public health providers of case management services for the CYSHCN population. (E)

66. Vaccines for Children

The Vaccines for Children (VFC) Program is available in private and public clinics. It provides vaccines at no charge to Medicaid children 0-18 years of age, Alaskan Native and Native American children 0-18 years and uninsured children. Children who are insured, but whose insurance would not cover vaccinations can also access VFC through the Federally Qualified Health Centers or the federally designated Rural Health Clinics. The administration fee for the vaccines provided through the Immunization Grant Program is be sliding, reduced or waived in the public clinics based upon the client's ability to pay. (PB)

67. WIC – Farmer's Market Nutrition Program

The WIC Farmer's Market Nutrition Program (FMNP) provides fresh fruits and vegetables to women and children who are nutritionally at risk and also supports local agriculture. The women and children receive \$16 in FMNP checks to spend on fruits, vegetables and herbs grown by local farmers. As of 2005, WIC has seven contracts with 9 markets in the following cities: Kalispell, Missoula, Hamilton, Helena, Billings, Miles City and Glasgow. The State is required to provide a 30% match for the administrative

funds received from the Department of Agriculture. In 2003, the total participation was 5,695 and \$39,042 was redeemed in food. In 2004, the total participation was 4,262 and \$32,774 was redeemed in food. 2004 participation was less than 2003 participation because of the difficulty of acquiring sufficient match for the FMNP food dollars (this is requirement has changed under new legislation). Due to a subsequent change in legislation, Montana expects to be able to meet the matching requirement for administrative funds and therefore be able to access all of the food dollars contained in the grant in future years. (E)

VIII. SUMMARY

Montana has many positive maternal and child health (MCH) indicators. Despite large distances between health care facilities, 97% of births in Montana take place in hospitals. The rate of breastfeeding in Montana has surpassed the Healthy People 2010 objective. 75% of women breastfeeding immediately postpartum. The rate of cesarean sections in Montana is below the Healthy People 2010 objective of no more than 15% of all live births. When compared to their national counterparts, Montana girls are less likely to become pregnant during their teenage years. Montana youth also tend to be more active and are less likely to experience violence at school than youth nationwide.

While several maternal and child health indicators show that Montana is doing well, Montana's MCH population still faces critical health issues. Foremost among these is access to care. Increased access to health care, health insurance oral health care, and mental health services are needed among all population groups. Improved access to preventive services is needed for all MCH populations from a young age. The rural nature of much of the state and small population base make access to care an issue that requires creative approaches, and the reality is that travel will most likely always be a necessary part of accessing some types of care for Montanans.

Although the percent of Montana infants born with low birth weight is below the national average, this rate is increasing in Montana. The number of women in need of publicly supported contraceptive services in Montana is also increasing. Montana's rate of youth suicide remains higher than the national average, although the rate is decreasing. Rates of smoking and alcohol use among teens are high in Montana, and stakeholders clearly identified prevention and treatment of alcohol and drug abuse as a need for adolescents.

Any challenges encountered by average Montanans in accessing health are exacerbated for children and youth with special health care needs (CYSHCN), who likely have to seek care more often, and travel farther to reach specialty providers.

One weakness in Montana's MCH needs assessment is the lack of information on disparities between racial and ethnic groups and between different areas of the state. Within Montana, there are large disparities in fetal, infant and child mortality rates between Native Americans and whites, with Native American children having higher mortality rates. Native American women and teens also report smoking more often than white women and teens. Specific data on other disparities are unavailable.

Montana's maternal and child health population continues to change. The far eastern portion of the state is losing population, particularly in the younger age groups, while the major population centers continue to grow. Poverty in Montana is increasing.

Essential components to addressing maternal and child health needs in Montana are supportive legislation and collaboration among partners. Supportive legislation can provide the framework to respond to identified needs. During the 2005 legislative session, Montana expanded the coverage of the Children's Health Insurance Program (CHIP) and Medicaid to include more people. Legislation was also passed that will assist small employers to provide health insurance for employees. It is hoped that these measures will increase access to health care among people previously uninsured.

In addition to legislation, coordination and collaboration among partners and activities is also needed. Few programs in Montana provide comprehensive services which include health care and dental, mental health and preventative services. Not enough of the existing targeted services are able to link clients to other resources. Montana's network of health providers is thin in some areas – particularly in the rural sections of the state, and the need for coordination is great.

As the programs and activities section of the needs assessment illustrates, much of the state's capacity is determined by funding from federal or other external sources. While such sources of funding are essential to address health needs, they present a challenge in coordinating the programs and services available within the state, particularly when such funding is not assured from year to year. Activities developed in response to funding opportunities must necessarily be responsive to funding requirements, instead of being developed to meet Montana's needs. More flexible sources of funding, such as the Preventive Health Block Grant, that can be used to fund critical activities that would otherwise be unfunded are becoming rare. Increased collaboration and communication among public health activities can provide a safety net so that when one program is unfunded, other resources can be identified. Within Montana there are multiple efforts to continue and improve collaboration and coordination of services and activities.

In a continuation of the MCH assessment and planning cycle, the Family and Community Health Bureau and partners will use this needs assessment to inform the strategic planning process, as Montana determines the most effective and appropriate means to address the needs of the maternal and child health population.

IX. Maternal and Child Health Data Resources, Montana, 2000-2005

Source	Year	Target Population
Asthma School Survey	1999-2001	Providers in the Helena area
BRFSS	Annually	Adults 18 and older
Communicable Disease	Continuous	
Dental Screening	2003-2004, 2004-2005	Children in kindergarten through 8 th grade
ECCS Environmental Scan, Internal and External	2005	
Environmental Public Health Tracking Community Health Assessments	2004	Communities
MBOMS	Continuous	Children identified as having a birth defect or abnormal condition
Medicaid	Continuous	
Montana Tumor Registry	Continuous	
PHDS	Continuous	
PRAMS	2002, Point-in-time	Women who have recently given birth
School Nurse Vision Screening Survey	2004	School Nurses
State EHDI Survey	2004	
Vital Statistics	Continuous	
YRBS	2001, 2003	Adolescents in grades 7-8 and 9-12
Family Planning	Continuous	Family Planning clients
Teen Pregnancy Resources & Data	Continuous	Teens (15-19)

X. Appendices

Montana Maternal and Child Health Needs Assessment, 2005

Appendix A: Annual Estimates of the Population by Sex and Age for Montana, April 1, 2000 to July 1, 2004

Table 2: Annual Estimates of the Population by Sex and Age for Montana: April 1, 2000 to July 1, 2004							
Sex and age	Population estimates					April 1, 2000	
	July 1, 2004	July 1, 2003	July 1, 2002	July 1, 2001	July 1, 2000	Estimates base	Census
BOTH SEXES	926,865	918,157	910,670	906,241	903,500	902,195	902,195
Under 5 years	52,510	52,863	53,385	52,777	54,596	54,869	54,869
5 to 9 years	53,352	54,929	56,903	58,068	61,200	61,963	61,963
10 to 14 years	61,601	63,776	65,919	66,299	68,760	69,298	69,298
15 to 19 years	70,075	70,911	71,699	72,038	71,482	71,310	71,310
20 to 24 years	69,604	67,377	64,503	62,190	59,181	58,379	58,379
25 to 29 years	55,388	52,939	50,964	50,563	51,051	51,104	51,104
30 to 34 years	51,364	51,510	51,603	52,189	52,185	52,175	52,175
35 to 39 years	55,261	56,830	59,235	62,789	65,974	66,580	66,580
40 to 44 years	72,470	73,431	74,343	75,608	75,451	75,361	75,361
45 to 49 years	77,913	77,130	76,037	75,423	73,893	73,398	73,398
50 to 54 years	74,266	71,393	68,334	67,069	62,676	61,690	61,690
55 to 59 years	60,227	55,982	52,994	49,065	47,559	47,174	47,174
60 to 64 years	46,285	43,994	41,095	39,694	38,305	37,945	37,945
65 to 69 years	36,700	35,315	34,205	33,367	32,625	32,541	32,541
70 to 74 years	29,389	29,553	29,999	29,893	29,971	29,978	29,978
75 to 79 years	24,963	25,148	24,553	24,720	24,710	24,703	24,703
80 to 84 years	17,264	17,490	17,993	18,137	18,318	18,390	18,390
85 years or more	18,233	17,586	16,906	16,352	15,563	15,337	15,337
Under 18 years	208,093	213,195	218,898	220,224	228,370	230,062	230,062
Under 5 years	52,510	52,863	53,385	52,777	54,596	54,869	54,869
5 to 13 years	101,627	105,608	109,277	110,836	115,681	116,747	116,747
14 to 17 years	53,956	54,724	56,236	56,611	58,093	58,446	58,446
18 to 64 years	592,223	579,870	568,116	563,548	553,943	551,184	551,184
18 to 24 years	99,049	96,661	93,511	91,148	86,849	85,757	85,757
25 to 44 years	234,483	234,710	236,145	241,149	244,661	245,220	245,220
45 to 64 years	258,691	248,499	238,460	231,251	222,433	220,207	220,207
65 years and over	126,549	125,092	123,656	122,469	121,187	120,949	120,949
16 years and over	746,428	733,170	720,801	715,068	704,297	701,423	701,423
18 years and over	718,772	704,962	691,772	686,017	675,130	672,133	672,133
15 to 44 years	374,162	372,998	372,347	375,377	375,324	374,909	374,909
Median age (years)	39.5	39.1	38.6	38.3	37.7	37.5	37.5

Montana Maternal and Child Health Needs Assessment, 2005

Appendix A: Annual Estimates of the Population by Sex and Age for Montana, April 1, 2000 to July 1, 2004

MALE	462,265	457,818	453,778	451,588	450,252	449,480	449,480
Under 5 years	27,231	27,368	27,642	27,202	28,071	28,212	28,212
5 to 9 years	27,332	28,235	29,152	29,837	31,430	31,822	31,822
10 to 14 years	31,613	32,623	33,774	34,007	35,373	35,657	35,657
15 to 19 years	36,083	36,537	36,888	37,062	36,854	36,789	36,789
20 to 24 years	36,063	34,921	33,558	32,469	30,805	30,345	30,345
25 to 29 years	28,922	27,761	26,687	26,278	26,391	26,389	26,389
30 to 34 years	26,389	26,170	26,005	26,230	26,086	26,060	26,060
35 to 39 years	27,510	28,210	29,295	31,112	32,603	32,877	32,877
40 to 44 years	35,606	36,060	36,560	37,018	37,110	37,065	37,065
45 to 49 years	38,224	37,963	37,696	37,728	37,162	36,907	36,907
50 to 54 years	37,429	36,197	34,836	34,303	32,119	31,615	31,615
55 to 59 years	30,715	28,566	26,907	24,833	24,064	23,864	23,864
60 to 64 years	23,145	22,004	20,491	19,823	19,123	18,936	18,936
65 to 69 years	18,094	17,349	16,627	16,100	15,822	15,810	15,810
70 to 74 years	13,488	13,666	13,992	14,177	14,089	14,045	14,045
75 to 79 years	11,417	11,384	10,921	10,952	10,941	10,941	10,941
80 to 84 years	7,042	7,084	7,296	7,207	7,245	7,264	7,264
85 years or more	5,962	5,720	5,451	5,250	4,964	4,882	4,882
Under 18 years	107,103	109,736	112,582	113,251	117,351	118,245	118,245
Under 5 years	27,231	27,368	27,642	27,202	28,071	28,212	28,212
5 to 13 years	52,160	54,138	55,956	56,847	59,403	59,951	59,951
14 to 17 years	27,712	28,230	28,984	29,202	29,877	30,082	30,082
18 to 64 years	299,159	292,879	286,909	284,651	279,840	278,293	278,293
18 to 24 years	51,219	49,948	48,432	47,326	45,182	44,580	44,580
25 to 44 years	118,427	118,201	118,547	120,638	122,190	122,391	122,391
45 to 64 years	129,513	124,730	119,930	116,687	112,468	111,322	111,322
65 years and over	56,003	55,203	54,287	53,686	53,061	52,942	52,942
16 years and over	369,432	362,687	356,145	353,271	347,882	346,292	346,292
18 years and over	355,162	348,082	341,196	338,337	332,901	331,235	331,235
15 to 44 years	190,573	189,659	188,993	190,169	189,849	189,525	189,525
Median age (years)	38.3	37.9	37.5	37.2	36.7	36.6	36.6
FEMALE	464,600	460,339	456,892	454,653	453,248	452,715	452,715
Under 5 years	25,279	25,495	25,743	25,575	26,525	26,657	26,657
5 to 9 years	26,020	26,694	27,751	28,231	29,770	30,141	30,141

Montana Maternal and Child Health Needs Assessment, 2005

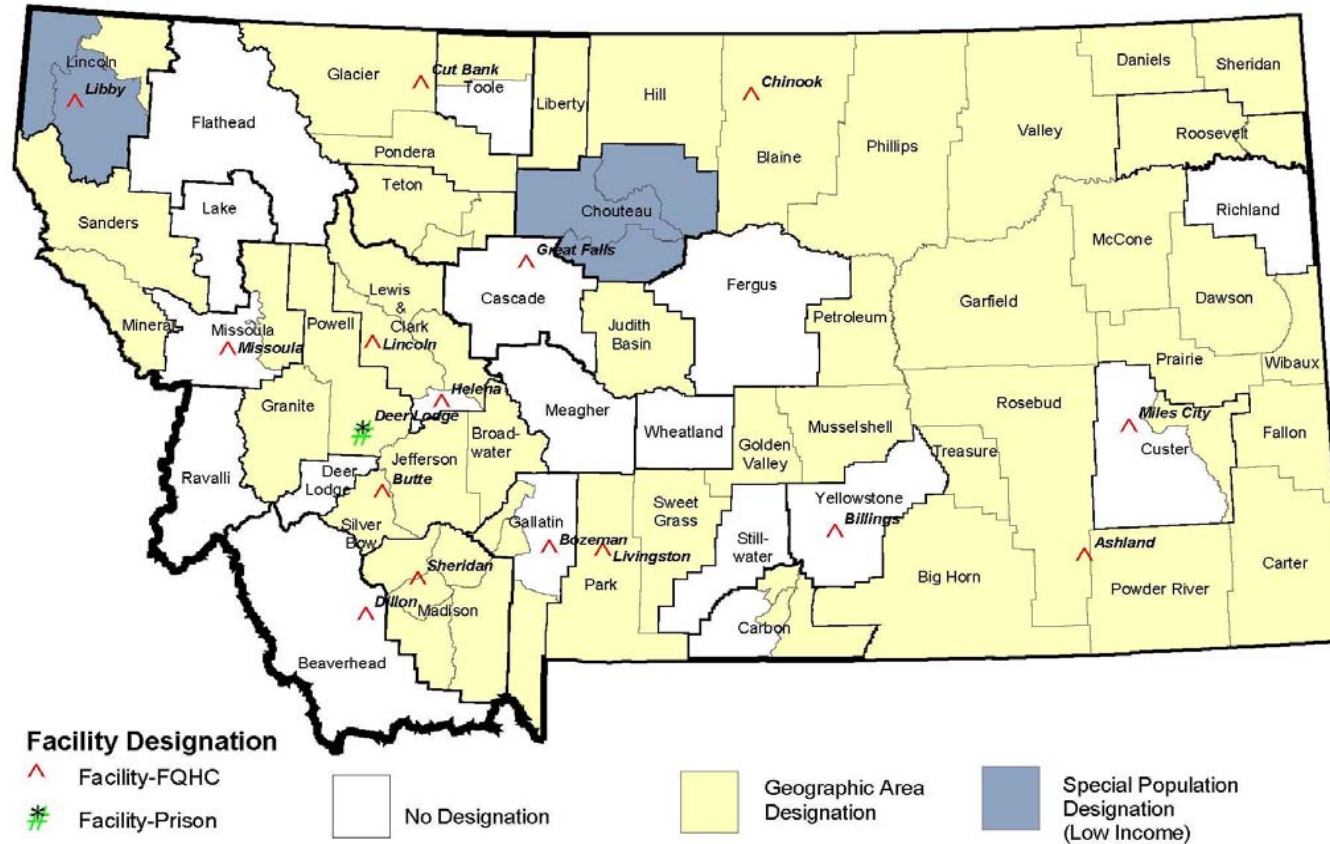
Appendix A: Annual Estimates of the Population by Sex and Age for Montana, April 1, 2000 to July 1, 2004

10 to 14 years	29,988	31,153	32,145	32,292	33,387	33,641	33,641
15 to 19 years	33,992	34,374	34,811	34,976	34,628	34,521	34,521
20 to 24 years	33,541	32,456	30,945	29,721	28,376	28,034	28,034
25 to 29 years	26,466	25,178	24,277	24,285	24,660	24,715	24,715
30 to 34 years	24,975	25,340	25,598	25,959	26,099	26,115	26,115
35 to 39 years	27,751	28,620	29,940	31,677	33,371	33,703	33,703
40 to 44 years	36,864	37,371	37,783	38,590	38,341	38,296	38,296
45 to 49 years	39,689	39,167	38,341	37,695	36,731	36,491	36,491
50 to 54 years	36,837	35,196	33,498	32,766	30,557	30,075	30,075
55 to 59 years	29,512	27,416	26,087	24,232	23,495	23,310	23,310
60 to 64 years	23,140	21,990	20,604	19,871	19,182	19,009	19,009
65 to 69 years	18,606	17,966	17,578	17,267	16,803	16,731	16,731
70 to 74 years	15,901	15,887	16,007	15,716	15,882	15,933	15,933
75 to 79 years	13,546	13,764	13,632	13,768	13,769	13,762	13,762
80 to 84 years	10,222	10,406	10,697	10,930	11,073	11,126	11,126
85 years or more	12,271	11,866	11,455	11,102	10,599	10,455	10,455
Under 18 years	100,990	103,459	106,316	106,973	111,019	111,817	111,817
Under 5 years	25,279	25,495	25,743	25,575	26,525	26,657	26,657
5 to 13 years	49,467	51,470	53,321	53,989	56,278	56,796	56,796
14 to 17 years	26,244	26,494	27,252	27,409	28,216	28,364	28,364
18 to 64 years	293,064	286,991	281,207	278,897	274,103	272,891	272,891
18 to 24 years	47,830	46,713	45,079	43,822	41,667	41,177	41,177
25 to 44 years	116,056	116,509	117,598	120,511	122,471	122,829	122,829
45 to 64 years	129,178	123,769	118,530	114,564	109,965	108,885	108,885
65 years and over	70,546	69,889	69,369	68,783	68,126	68,007	68,007
16 years and over	376,996	370,483	364,656	361,797	356,415	355,131	355,131
18 years and over	363,610	356,880	350,576	347,680	342,229	340,898	340,898
15 to 44 years	183,589	183,339	183,354	185,208	185,475	185,384	185,384
Median age (years)	40.6	40.1	39.6	39.2	38.6	38.5	38.5

Note: The April 1, 2000 Population Estimates base reflects changes to the Census 2000 population from the Count Question Resolution program and geographic program revisions. Dash (-) represents zero or rounds to zero. (X) Not applicable

Suggested Citation:
Table 2: Annual Estimates of the Population by Sex and Age for Montana: April 1, 2000 to July 1, 2004 (SC-EST2004-02-30)
Source: Population Division, U.S. Census Bureau
Release Date: March 2005

Montana Primary Care Health Professional Shortage Areas (HPSAs)



Montana Survey of Maternal and Child Health Needs

1. What are the most important **health needs** of infants, children, adolescents and women in Montana? For each of the four groups below, please read through the list of health needs, choose the 5 that you think are the most important and write the letters of those health needs in the blanks provided at the top of each section. Please fill out the blanks for each group, even if you don't have children in that age group or women in your household.

Infants and Young Children (children 5 years old and younger)	Children (children 6 years to 11 years)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ a. Access to dental care b. Access to health care c. Birth defects prevention and programs d. Child abuse and neglect services e. Health care services for children with special needs, such as a disability f. Health insurance g. Immunizations h. Mental health services i. Newborn screening for inherited health problems and/or hearing loss j. Obesity prevention k. Safe and affordable child care l. Sudden Infant Death Syndrome (SIDS) Other (please write in any other issues you think are important): m. _____ n. _____	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ a. Access to dental care b. Access to health care c. Asthma diagnosis and treatment d. Child abuse and neglect services e. Health care services for children with special needs, such as a disability f. Health insurance g. Immunizations h. Mental health services i. Motor vehicle safety j. Obesity prevention k. Safe and affordable child care l. School health services Other (please write in any other issues you think are important): m. _____ n. _____
Adolescents (ages 12 to 21 years old)	Women (women who are pregnant or who have recently had a baby)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ a. Access to dental care b. Access to health care c. Alcohol and drug abuse prevention and treatment d. Asthma diagnosis and treatment e. Child abuse and neglect services f. Health insurance g. Mental health services h. Motor vehicle safety i. Obesity prevention j. Pregnancy prevention k. School health services l. Sexual health education m. Sexually transmitted disease (STD)/HIV prevention and treatment n. Suicide prevention o. Tobacco use (smoking and chewing) prevention and treatment p. Violence towards or from other adolescents Other (please write in any other issues you think are important): q. _____ r. _____	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ a. Access to dental care b. Access to health care (other than prenatal care) c. Alcohol and drug use prevention and treatment d. Birth control services e. Breast and cervical cancer screening f. Breastfeeding support g. Domestic violence services h. Health insurance i. Home visiting services j. Mental health services k. Nutrition during pregnancy and while breastfeeding l. Parenting education m. Postpartum depression services n. Prenatal care o. Sexually transmitted disease (STD)/HIV prevention and treatment p. Tobacco use (smoking and chewing) prevention and treatment Other (please write in any other issues you think are important): q. _____ r. _____

2. What are the ages of the children in your household? *(please check all that apply)*

☐ 5 years old and younger
 ☐ 6 to 11 years old
 ☐ 12 to 21 years old

3. Are there any women in your household (including yourself) who are currently pregnant or have had a baby in the past 5 years? *(please check one)*

☐ Yes
 ☐ No

4. How far away from where you live is this **WIC Clinic**? *(please check one)*

☐ Less than ½ hour's drive
 ☐ ½ hour to 1 hour's drive
 ☐ More than 1 hour's drive

Please turn this page over and continue with page 2



5. During your most recent pregnancy, did you or your partner receive **prenatal care** (a visit with a doctor, nurse or other health care worker after you found out you were pregnant, not including a visit to a WIC clinic)?

☐ Yes ➡ a) What is the distance you or your partner travel(ed) to your usual source of **prenatal care**? (please check one)

☐ Less than ½ hour's drive ☐ ½ hour to 1 hour's drive ☐ More than 1 hour's drive

☐ No ➡ b) If you or your partner did not receive **prenatal care**, why not? (please check all that apply)

☐ Did not need prenatal care ☐ Did not have child care for other children

☐ Could not get an appointment ☐ Did not know where to get prenatal care

☐ Could not afford the cost of the services ☐ Services were too far away

☐ Did not have insurance coverage ☐ Could not find transportation to get to the services

☐ Other (please specify) _____

6. When your last child was born, did you or your partner receive **help with breastfeeding** (from a nurse or lactation specialist or at a WIC clinic)?

☐ Yes ➡ a) What is the distance you or your partner travel(ed) to your usual source of **help with breastfeeding**? (please check one)

☐ Less than ½ hour's drive ☐ ½ hour to 1 hour's drive ☐ More than 1 hour's drive

☐ No ➡ b) If you or your partner did not receive **help with breastfeeding** when your last child was born, why not? (please check all that apply)

☐ Did not breastfeed ☐ Did not know where to find breastfeeding help

☐ Did not need help with breastfeeding ☐ Services were too far away

☐ Could not afford the cost of the services ☐ Could not find transportation to get to the services

☐ Other (please specify) _____

7. In the past 5 years, have you or your partner received **domestic violence services** (including counseling services, shelters, legal aid or law enforcement intervention)?

☐ Yes ➡ a) Which of the services that you or your partner received were available within one hour's drive of your home? (please check all that apply)

☐ Counseling ☐ Shelter ☐ Legal aid ☐ Law enforcement ☐ Other _____

☐ No ➡ b) If you or your partner have not used **domestic violence services** in the past 5 years, why not? (please check all that apply)

☐ Did not need domestic violence services ☐ Did not know where to find domestic violence services

☐ Could not afford the cost of the services ☐ Services were too far away

☐ Did not have child care for children ☐ Could not find transportation to get to the services

☐ Other (please specify) _____

8. In the past 5 years, have you or your partner ever used **family planning services** (birth control, pregnancy testing, breast and cervical cancer screening, or STD/HIV testing and treatment)?

☐ Yes ➡ a) What is the distance you or your partner travel to your usual source of **family planning services**? (please check one)

☐ Less than ½ hour's drive ☐ ½ hour to 1 hour's drive ☐ More than 1 hour's drive

☐ No ➡ b) If you/your partner have not used **family planning services** in the past 5 years, why not? (please check all that apply)

☐ Did not need family planning services ☐ Did not know where to find family planning services

☐ Could not afford the cost of the services ☐ Services were too far away

☐ Did not have child care for children ☐ Could not find transportation to get to the services

☐ Other (please specify) _____

9. In the past 5 years, has your child or children ever received **dental care**?

☐ Yes ➡ a) What is the distance you travel to your child or children's usual source of **dental care**? (please check one)

☐ Less than ½ hour's drive ☐ ½ hour to 1 hour's drive ☐ More than 1 hour's drive

☐ No ➡ b) If your child or children have not received **dental care** in the past 5 years, why not? (please check all that apply)

☐ Did not need dental care ☐ Did not have child care for children

☐ Could not find a provider of dental services ☐ Did not know where to find dental services

☐ Could not afford the cost of the services ☐ Services were too far away

☐ Did not have insurance coverage ☐ Could not find transportation to get to the services

☐ Other (please specify) _____

10. Is there anything else you would like to tell us?

When you are finished with the survey, please seal it in the envelope provided and hand it back to the WIC or Head Start staff. If you have questions or comments, please contact Dianna Frick at: dflick@mt.gov or (406) 444-6940. Our mailing address is: Family and Community Health Bureau, DPHHS, Cogswell Building, Room C-314, 1400 Broadway, Helena, MT 59620.

Thank you for your help!

Montana Survey of Maternal and Child Health Needs

When you are finished with the survey, please seal it in the stamped, addressed envelope provided and return it to: D. Frick, DPHHS, Family and Community Health Bureau, 1400 Broadway, PO Box 202951, Helena, MT 59620. Questions can be directed to Dianna Frick at 406-444-6940 or dfrick@mt.gov.

Thank you for your help.

1. What are the ages of the children you provide services to? *(please check all that apply)*

- ☐ 5 years old and younger ☐ 6 to 11 years old ☐ 12 to 21 years old

2. Do you provide services to pregnant, post-partum, or breastfeeding women? *(please check one)*

- ☐ Yes ☐ No

3. What are the most important **health needs** of infants, children, adolescents and women in Montana? For each of the four groups below, please read through the list of health needs, choose the 5 that you think are the most important **based on your interactions with clients**, and write the letters of those health needs in the blanks provided to the right of each list of health needs. Then, please estimate the **average** distance your clients must travel for services to address the health needs you've identified. Even if you don't provide services for one of the groups, please tell us what you think are the health needs and distance to health services for that group.

Infants and Young Children (children 5 years old and younger)

- | | | |
|---|----------|---|
| a. Access to dental care | 1. _____ | What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i> |
| b. Access to health care | | <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
| c. Birth defects prevention and programs | 2. _____ | What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i> |
| d. Child abuse and neglect services | | <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
| e. Health care services for children with special needs, such as a disability | 3. _____ | What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i> |
| f. Health insurance | | <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
| g. Immunizations | 4. _____ | What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i> |
| h. Mental health and counseling services | | <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
| i. Newborn screening for inherited health problems and/or hearing loss | 5. _____ | What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i> |
| j. Obesity prevention | | <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
| k. Safe and affordable child care | | |
| l. Sudden Infant Death Syndrome (SIDS) | | |
| Other (please write in any other issues you think are important): | | |
| m. _____ | | |
| n. _____ | | |

Children (children 6 years to 11 years)

- | | | |
|---|----------|---|
| a. Access to dental care | 1. _____ | What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i> |
| b. Access to health care | | <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
| c. Asthma diagnosis and treatment | 2. _____ | What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i> |
| d. Child abuse and neglect services | | <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
| e. Health care services for children with special needs, such as a disability | 3. _____ | What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i> |
| f. Health insurance | | <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
| g. Immunizations | 4. _____ | What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i> |
| h. Mental health and counseling services | | <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
| i. Motor vehicle safety | 5. _____ | What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i> |
| j. Obesity prevention | | <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
| k. Safe and affordable child care | | |
| l. School health services | | |
| Other (please write in any other issues you think are important): | | |
| m. _____ | | |
| n. _____ | | |



Adolescents (ages 12 to 21 years old)

- | | |
|---|---|
| <ul style="list-style-type: none"> a. Access to dental care b. Access to health care c. Alcohol and drug abuse prevention and treatment d. Asthma diagnosis and treatment e. Child abuse and neglect services f. Health insurance g. Mental health and counseling services h. Motor vehicle safety i. Obesity prevention j. Pregnancy prevention k. School health services l. Sexual health education m. Sexually transmitted disease (STD)/HIV prevention and treatment n. Suicide prevention o. Tobacco use (smoking and chewing) prevention and treatment p. Violence towards or from other adolescents Other (please write in any other issues you think are important): q. _____ r. _____ | <ul style="list-style-type: none"> 1. _____ What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i>
 <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive 2. _____ What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i>
 <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive 3. _____ What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i>
 <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive 4. _____ What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i>
 <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive 5. _____ What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i>
 <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
|---|---|

Women (women who are pregnant or who have recently had a baby)

- | | |
|--|---|
| <ul style="list-style-type: none"> a. Access to dental care b. Access to health care (other than prenatal care) c. Alcohol and drug use prevention and treatment d. Birth control services e. Breast and cervical cancer screening f. Breastfeeding support g. Domestic violence services h. Health insurance i. Home visiting services j. Mental health and counseling services k. Nutrition during pregnancy and while breastfeeding l. Parenting education m. Postpartum depression services n. Prenatal care o. Sexually transmitted disease (STD)/HIV prevention and treatment p. Tobacco use (smoking and chewing) prevention and treatment Other (please write in any other issues you think are important): q. _____ r. _____ | <ul style="list-style-type: none"> 1. _____ What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i>
 <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive 2. _____ What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i>
 <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive 3. _____ What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i>
 <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive 4. _____ What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i>
 <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive 5. _____ What would you estimate is the average distance the clients you work with would have to travel for services to address this health need? <i>(please check one)</i>
 <input type="checkbox"/> Less than ½ hour's drive <input type="checkbox"/> ½ hour to 1 hour's drive <input type="checkbox"/> More than 1 hour's drive |
|--|---|

4. a) Would the information collected in this statewide assessment of maternal and child health (MCH) needs be useful to you or your organization?

☐ Yes ☐ No *(please skip to question 5)*

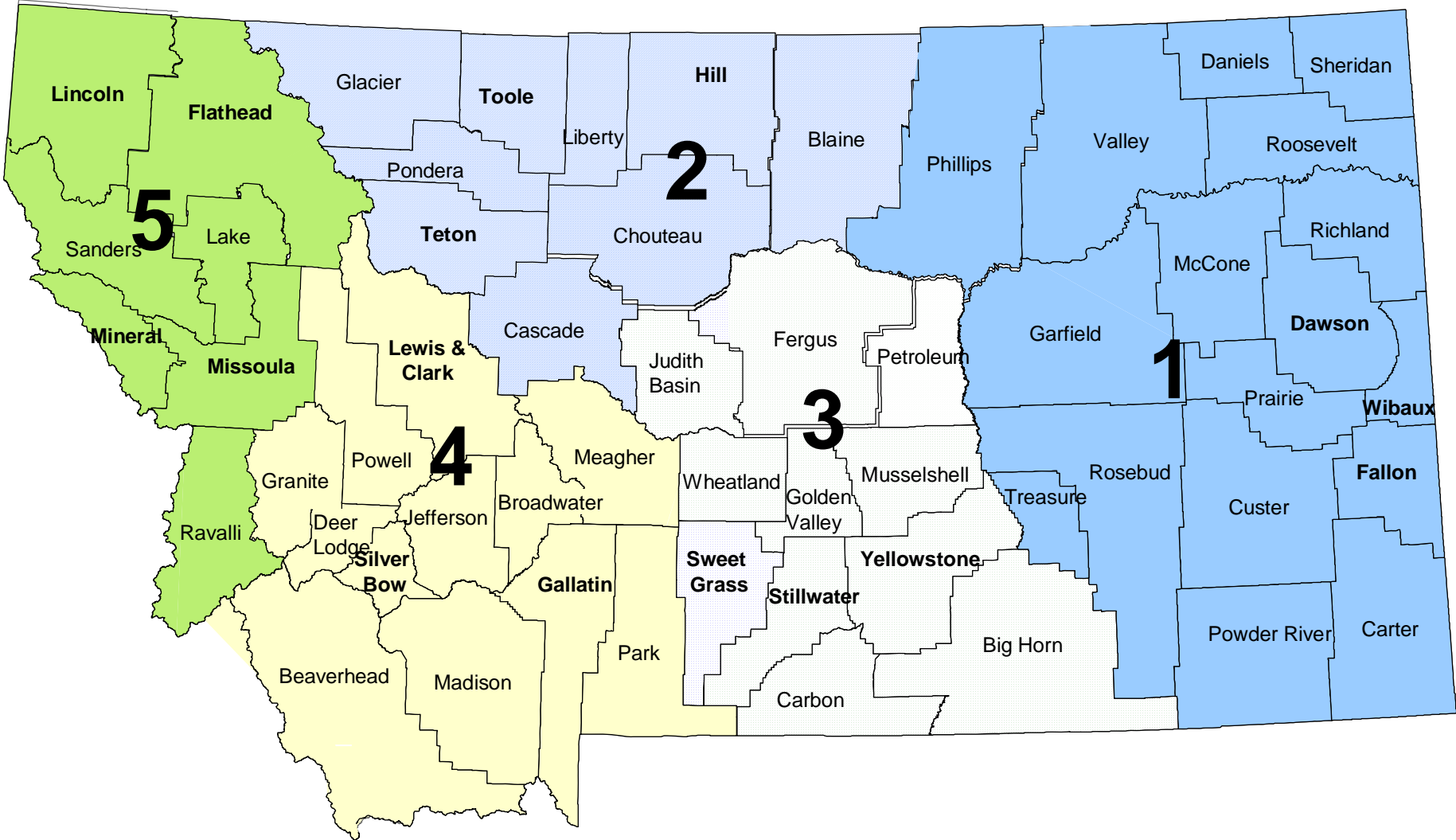
b) If yes, how could you or your organization use this information? *(please check all that apply)*
☐ Grant/funding applications ☐ Reports to local boards of health or consumers ☐ Other *(please specify)* _____

5. What type of information on maternal and child health (MCH) needs would be useful to you or your organization? *(please check all that apply)*
☐ MCH needs by county ☐ MCH needs by health planning region ☐ Statewide MCH needs ☐ Other *(please specify)* _____

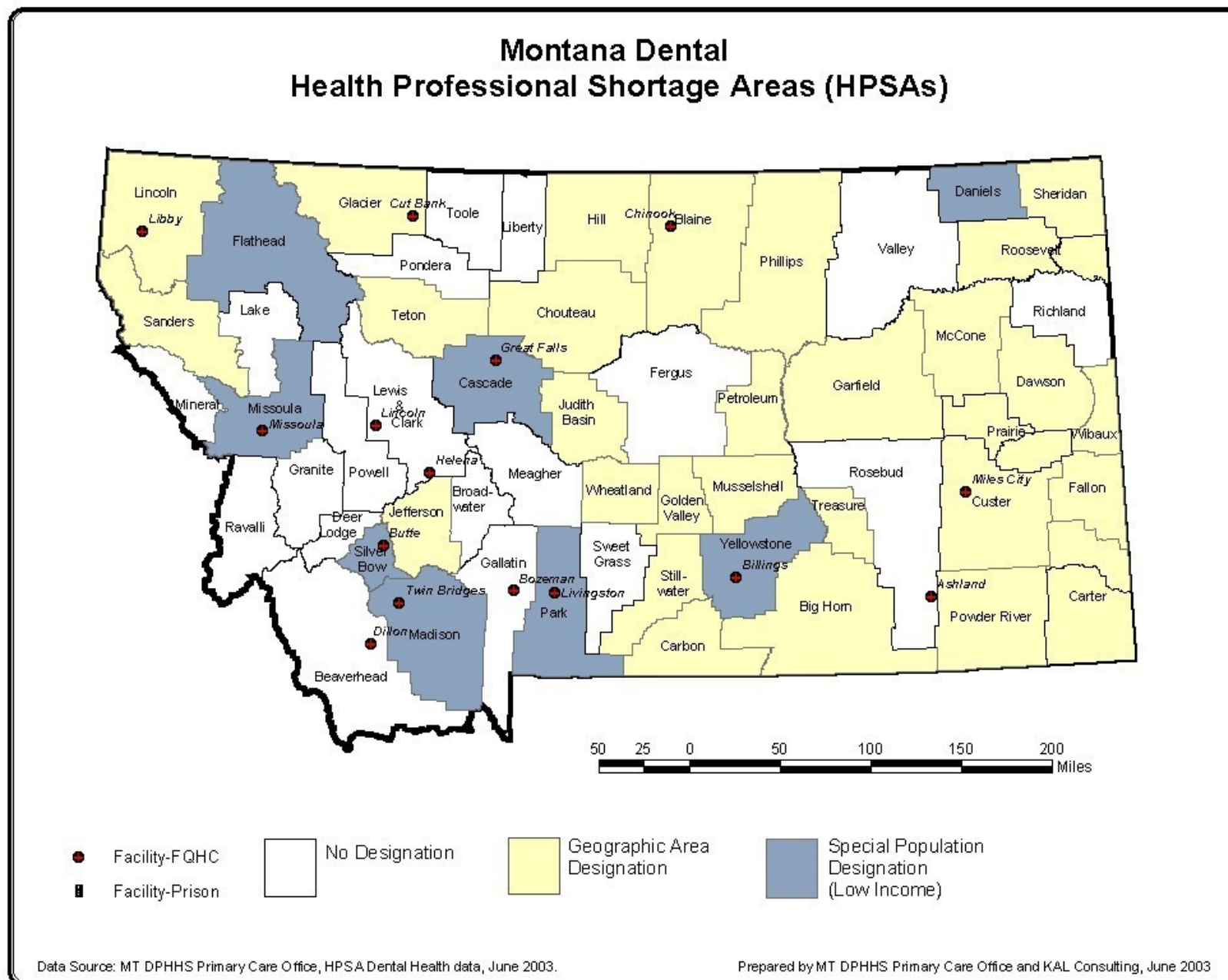
6. Do you have access to the internet at work? ☐ Yes ☐ No

7. Is there anything else you would like to tell us?

Montana Health Planning Regions



Appendix F: Montana Dental Health Professional Shortage Areas (HPSAs)



Internal Environmental Scan and Capacity:

Perhaps the sole benefit of the small size of the public health service community in Montana is that coordination of services becomes a relatively easy process. The fact that few people wear many hats at both the state and local levels and in the private and not-for-profit communities usually results in more thorough coordination of the available services. Everyone knows everyone and many clients are served in common. People work diligently to meet local client needs as efficiently and effectively as scarce resources allow. Local input is sought at the state level, usually in the form of advisory councils or committees composed of parents, client advocacy groups, local health providers, and legislators. As the Montana ECCS is developed, there are advantages to looking at children services in some type of interagency forum.

Access to Health Insurance and Medical Homes:

The Public Health and Safety Division (PHSD) within the Department of Public Health and Human Services (DPHHS) is responsible for most public health programs, including the Maternal Child Health (MCH) and Children's Special Health Care Needs (CSHCN) programs. The MCH and CSHCN services as described in Title V of the Social Security Act are managed in two Bureaus in two divisions within the DPHHS. The Family and Community Health Bureau (FCHB) is the primary MCH agency, responsible for development of the MCHBG report and plan, budget monitoring, and implementation of the plan. The Health Care Resources Bureau includes the Children's Special Health Services program, which is the unit responsible for services to children with special health care needs and their families and is located in the Child and Adult Health Resources Division.

Efforts to integrate and coordinate services to the MCH target population of pregnant women and infants, children, including those with special health care needs and adolescents, childbearing women and the families of all target populations have been ongoing over the last decade. Staff at the state level is able to work closely together to decrease administrative burden and streamline reporting requirements for local contractors/partners. Over half of Montana's local health departments are "one man shops", with a public health nurse, and possibly an administrative assistant responsible for implementation of numerous state programs. Since 1999, all counties have a standard MCH contract, requiring them to provide services to the MCH population.

The Universal Newborn Hearing Screening Task Force continues to advise the state program on the implementation of this screening program. The Newborn Screening Advisory Committee also provides invaluable advice to the Division (including the Public Health Laboratory, the newborn screening monitoring program, and the birth defects registry).

The Children's Special Health Services section of the Health Care Resources Bureau contracts with in- and out-of-state consultants. The State CHIP program is contained in the HCRB and collaboration with Medicaid is an integral part of operations. The CSHS section receives input and guidance from an advisory group consisting primarily of medical providers, but also including parent participants and advisors. Jo Ann Dotson, the Bureau chief of the Family and Community Health Bureau and co-director of the ECCS, participates as a staff member on the

CSHS Advisory Group. CSHS coordinates services and activities directly with providers through the Montana Chapter of American Academy of Pediatrics, an advisory committee, public payers such as SCHIP, state employee benefits plan and Medicaid, the Family Voices chapter housed at Parents Lets Unite for Kids (PLUK), the Insurance Commissioners Office and others. CSHS continues to expand their ability to coordinate services with other partners who work with CSHCN. In Montana much of this activity occurs at the local level through service providers. CSHS chooses to work toward coordination at a state level.

The coordination between the Health Care Resources Bureau (HCRB) and the Family and Community Health Bureau is integral to the smooth operation of the Children's Health Referral and Information System (CHRIS). This data system is managed in both HCRB and in the FCHB. The CSHCN service monitoring and referral portion of the system is managed in HCRB; the population-based birth defects registry is managed in the FCHB. The population-based newborn screening monitoring program in FCHB makes referrals to the CSHS staff for confirmed cases of selected abnormal metabolic screening results. The two Bureaus cooperated in the development of the 2003-2006 SSDI grant application with the intent of linking the CHRIS, the PHDS, Part C and Montana School for the Deaf and Blind via a web application for CSHCN referral purposes.

The Children's Special Health Services (CSHS) section in the Health Care Resources Bureau administers 30% of the MCHBG. Services are provided to Montana children with special health care needs and their families by the CSHS program staff and their contractors. Services include case identification and referral, consultation and technical assistance, clinical programs and staffing, regional clinic coordination in two locations, and direct payment of medical services for eligible children who have no source of payment for needed care. The number of children receiving direct pay services has decreased as insurance coverage becomes more available. In Montana, CSHCN program eligibility is based on diagnosis/condition and financial eligibility. CSHS has worked with various stakeholders regarding the need for systems to reflect common values for the benefit of all CSHCN, while also promoting access to community-based systems of care and decreasing competition among programs for dwindling resources. CSHS works with State agencies and private business to insure access to community based care. This includes partnering with private organizations to provide case management services to CSHCN where public health resources are not available. Coordination of services with Medicaid, dental, durable medical, home and community based waivers and the transportation programs are to improve the outcomes for CSHCN. Collaboration with the medical centers in Billings and Missoula have resulted in family-centered pediatric specialty clinics, insuring that specialists are available to families locally, reducing or eliminating the burden of out of state travel for medical care. CSHS has also begun to research the capacity of local county health departments to participate in targeted case management for CSHCN. CSHS has begun to promote the need to provide community-based care for CSHCN, regardless of their diagnosis or disability. Bringing new partners to the table, such as Early Intervention (Part C), and the Montana School for the Deaf and Blind has provided CSHS the ability to stress the need to promote the core values in providing care to all CSHCN. This activity has increased the capacity of the program by decreasing the duplication among these providers. Continual collaborative efforts will further streamline the system for families. The ability to support and provide case management for

CSHCN has expanded due to the increase in the number of private firms that have shown an interest in the activity. Additionally, emphasis on provider education has brought some public health departments back to providing this service. The beginning of cross system coordination is occurring to assist families in choosing the appropriate case manager for their child's situation.

Mental Health and Social Emotional Development:

Staff members also devote a great deal of time and energy to the Public Health Improvement and Turning Point projects. Bureau staff members continue to participate on the Public Health Training Institute committee. Bureau staff members also served on the State Incentive Grant Advisory Council and on the management team for a \$3 million grant that provides funding to local communities to help them decrease substance abuse.

The Head Start/State Collaboration Office committed a portion of a 2004-2005 supplemental grant to the ECCS planning efforts in the area of mental health. This money was used to create a mental health grant for Early Childhood Mental Health Consultation. The notification of a successful grant award will be made June 17, 2005.

Early Care and Education/Child Care:

Montana's oral health program has worked closely with the Primary Care Office and Primary Care Association over the last several years to focus education and cooperation regarding the importance of oral health and the serious access issues that exist in our state. The Oral Health program also works in conjunction with the WIC, Head Start, Healthy Child Care Montana and the Child, Adult Care Food Program to develop appropriate services for the preschool population.

The Healthy Child Care Montana project has been a contract activity with a local health department, to help develop resources and services, which may improve the health and safety in child care settings. State and local staff have worked to mainstream the efforts to coordinate public health and childcare provider efforts. The transitioning of the federal funding toward the ECCS development will capitalize on the partnerships developed.

Parenting Education:

The WIC section supports a local WIC directors group and also facilitates statewide exchange of information for nutritionists through their annual meetings. In 2003, groups representing partnerships of local and state WIC staff and local health department administrators undertook a "restructuring" effort. The group is redesigning WIC service contracting and coordination, with regionalization incorporated into the design. The contracts reflecting the redesign began in October 2004.

The Child, Adolescent, and Community Health section monitored the Healthy Child Care CISS grant and worked with the advisory council for that grant. The Montana Statewide FASD project is administered from the CACH section and supports the FAS advisory council appointed by the governor at the end of June 2001. Montana was recently awarded a grant in 2004. The FASD crosses every system of care and affects every community. With the funding, Montana has ten months to plan. Ultimately, we will develop FASD policies and procedures, integrate FASD

services into an existing system of care or develop a system of care, and find ways to continue the project after funding ends. When part of the Four State FAS Consortium, Montana implemented a pilot project in 2002 to provide home visits for women at risk of drinking during pregnancy. Contracts were developed with four sites to implement and test the prevention intervention, and a prenatal questionnaire was developed and implemented in sites across Montana to find out the numbers of pregnant women who are drinking during their pregnancy. The project also sponsored diagnostic clinics in two areas of the state to help estimate the prevalence of children affected by alcohol in utero.

Family Support:

In 1999 the Family and Community Health Bureau Advisory Council formalized its creation with election of officers and generation of bylaws. The Advisory Committee continues to be instrumental in the development and on-going assessment of the Strategic Plan for the Family and Community Health Bureau, consults with program staff on the PRAMS project, the SSDI grant, intra- and inter-departmental coordination efforts, the birth defects registry educational program, the WIC program, women's and men's health initiatives, and community and adolescent health concerns. The bureau chief of the Health Systems Bureau participates as a staff member on the FCHB Advisory Council. The FCHB Advisory Council members provided effective advocacy for MCH programs during the 2005 State Legislature and played key roles in preserving the state's general fund support of the locally fielded, high-risk pregnancy intervention program, MIAMI.

The Women's Health section supports and staffs a Medical Advisory Committee. The family planning directors are a privately incorporated council who pay dues and maintain membership. These directors meet quarterly with Title X staff. This section also supports the gubernatorial Abstinence Advisory Council charged with monitoring and advising the Department on implementation of the Title V Abstinence Program Grant.

Other Capacities of MCH:

The staff members of the Family and Community Health Bureau (FCHB) are active participants on many intra- and inter-departmental committees. They are also represented on statewide and national planning organizations. Bureau staff members participate on committees and councils at the request of agencies and departments in the state, including a statewide Initiative on Nursing Transformation funded by the RWJ Colleagues for Caring Program, and on an RFP review committee on a competitive grant for designation of Drug Free Schools for the Office of Public Instruction.

The development of detailed system requirements, user acceptance testing, and testing of enhancements as well as provision of on-going local support for users of the Public Health Data System (PHDS) have required extensive time commitments from program staff of the Immunization program in one Bureau, and from staff of CACH, Women's and Men's Health and MCH Data Monitoring sections in another Bureau. PHDS has been rolled out to all counties that have requested the integrated data system and plans. (Only 7 counties have not requested PHDS, all of which are small and some of which do not yet have the required internet connectivity to

support the central database transmission to and from Helena.) The local public health departments that comprise the User Group of the PHDS act as the advisory group for the ongoing maintenance and enhancement of the system. 83% of the local public health departments are currently using the PHDS. System enhancements continue to be made to meet needs of both larger and smaller health department users of the system.

Jo Ann Dotson, chief of the FCHB, began participating with the new Kids Count project advisory committee in the fall of 2000. This activity was facilitated by the Bureau of Business and Research of the University of Montana and resulted in the production of a new Montana Kids Count status book in 2001 with the most recent update in 2004. Both entities are active participants in the ECCS.

Bi-monthly meetings are held with the Office of Public Instruction in order to discuss issues that cross-departmental boundaries, such as dispensing medications in the schools, management of biohazards in schools and management of asthma.

State Performance Measures – ECCS Issues:

- State Performance Measure 1: Percent of unintended pregnancy.
- State Performance Measure 2: Percent of women who abstain from alcohol use in pregnancy.
- State Performance Measure 4: Percent of "WIC" infants who are breastfed at six months.
- State Performance Measure 7: Percent of two-year-old children screened for lead.
- State Performance Measure 8: Percent of Medicaid eligible children who receive dental services as part of their comprehensive services.
- State Performance Measure 9: Percent of pregnant women who abstain from cigarette smoking.

(Developing – anticipated completion date – February 2006)

Work to date on external environmental scans:

In January 2004 at the first meeting of the ECCS Task Force, all members were asked to place their agency/organization in the continuum of services offered to young children. This began the process of identifying the multitude of already existing services. Each Task Force member (X number representing a broad array of organizations) was asked to identify where they fit within the Ecological Model of Child Health Development. This produced a first step at showing the pre-existing services.

Ecological Perspective:

- Focuses on an individual's relationship within his/her social contexts
- Human development occurs in a set of overlapping ecological systems.
- All of these systems operate together to influence what a person becomes as he/she develops.
- MICROSYSTEM - Immediate social settings which an individual is involved in.
- MESOSYSTEM - Links 2 Microsystems together, direct or indirectly.
- EXOSYSTEM - Settings in which the person does not actively participate in but in which significant decisions are made affecting the individuals who do not interact directly with the person.
- MACROSYSTEM - "Blueprints" for defining and organizing the institutional life of the society, including overarching patterns of culture, politics, and economy.

In May/June 2004 twelve community forums were held around the state to bring local input in to the ECCS process. As part of the forums, participants were asked to identify problems associated with early childhood and what they think are critical things that need to happen in a system designed to develop healthy young children who are ready to go to school to learn. This process yielded a wealth of information that will be used in creating the final External Environmental Scan, as it is a product of front line workers and personnel critical to implementing an ECCS Plan.

In October 2004 a report on best practices was presented to the ECCS Task Force that summarized and critically analyzed early childhood programs within the five key component areas on the national, state and local levels. This document identified many successful programs in Montana and thus contributes to the external environmental scan.

In January 2005 the ECCS Task Force, using the Needs Assessment Framework developed by Health Systems Research, Inc., assessed the current status of services to young children looking at the system as a whole and then at services under each of the five key components. They were then asked if anything was being done or in the planning stages to be done under a series of questions pertaining to services for young children. The ECCS Core Group then added input to this Task Force created document to bring more in-depth knowledge. This document will be key in developing the final External Environment Scan.

In April 2005 at this Task Force meeting, members finalized the desired results for Montana's ECCS and used these to conclude most of the data collection stage of producing the External Environmental Scan by identifying. The creation of the results and the external environmental scan is still an open-ended document as gathering input from the community still needs to be done.

The Task Force listed the existing services available to young children and their families under each of the nine results then identified at least two problems that they know exists as barriers for getting the desired result from the current environment. They finished by naming what is currently working successfully under that result. This document will be used as a framework for synthesizing all collected information to produce the final External Environmental Scan.

In Montana, there are early childhood systems and initiatives that will be included in the final draft of the external scan. These are the ones that have been identified to date:

- Early Childhood Services Bureau:
 - Child Care Subsidy, CACFP, Best Beginnings, Early Childhood Career Development, Early Learning Guidelines, Child Care R&R's
 - Temporary Assistance to Needy Families –
 - Family Support – job skills, parent education, child care, transportation, welfare
 - Food stamps, counseling
- Office of Public Instruction:
 - Reading First, Comprehensive System of Personnel Development, Even Start, Title I
 - Children's Mental Health Bureau
 - Early Intervention and Part C
 - Medicaid/CHIP
 - Head Start/Early Head Start

Next Steps: Documents will be synthesized and a draft document will be sent to the ECCS Core group to identify gaps and for further analysis.